

Patient Health Profile

The following information is to assist the doctor and will be kept in confidence.

Patient's name _____

Today's date dd/mm/yy: _____

For Women Only

Date of last menstrual period dd/mm/yy: _____

Are you currently using any contraception YES NO

Are you pregnant YES NO

Health Assessment

Rate your overall health;

Excellent

Good

Poor

Do you get regular checkups from a;

Dentist

Chiropractor

Medical Doctor

Do you exercise;

Daily

3times/wk

Once/wk

Occasionally

When you exercise do you work on; Strength Flexibility Cardiovascular

Any prior surgery _____

Medications or nutritional supplements presently taken _____

All previous accidents (motor vehicle, sports or falls) _____

Current Health Complaint

Chief complaint _____

When did the problem begin dd/mm/yy: _____

The onset of this problem was: Gradual

Sudden

The occurrence of symptoms is

Constant

Near constant

Frequent

Rarely present

Other

The problem is worse with

Coughing

Sneezing

Straining

Sleeping

Lifting

Rest

Activity

Weather changes

Other

The problem is better with

Medication

Rest

Activity

Stretching

Treatment

Other

Please rate the intensity of your pain by placing an "X" at the appropriate point

0 1 2 3 4 5 6 7 8 9 10

ADJUSTED FOR LIFE
CHIROPRACTIC HEALTH CENTRE



ADDING LIFE TO YOUR YEARS

Dr. Les J. Davidson

100,2001-14th St. N.W.
T2M 3N3

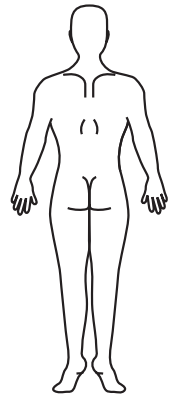
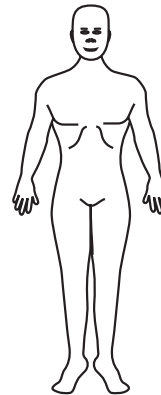
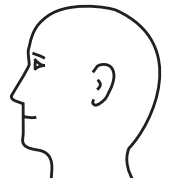
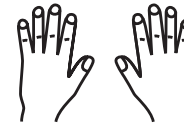
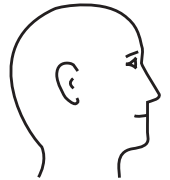
Calgary Alberta
403 284 4743

Health complaint diagram

Mark the areas on your body where you feel the described sensations. Please include all affected areas.

Please use the following symbols.

Numbness —
 Pins and Needles //
 Burning =
 Stabbing pain ▽
 Aching pain ○



Health Questionnaire

Musculo-skeletal system

| | HAD | HAVE |
|------------------------|--------------------------|--------------------------|
| Low back pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain between shoulders | <input type="checkbox"/> | <input type="checkbox"/> |
| Neck pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Arm pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen joints | <input type="checkbox"/> | <input type="checkbox"/> |
| Stiff joints | <input type="checkbox"/> | <input type="checkbox"/> |
| Sore muscles | <input type="checkbox"/> | <input type="checkbox"/> |
| Weak muscles | <input type="checkbox"/> | <input type="checkbox"/> |
| Walking difficulty | <input type="checkbox"/> | <input type="checkbox"/> |
| Broken bones | <input type="checkbox"/> | <input type="checkbox"/> |

Nervous system

| | | |
|----------------------|--------------------------|--------------------------|
| Numbness | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of feeling | <input type="checkbox"/> | <input type="checkbox"/> |
| Paralysis | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| Muscle jerking | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions | <input type="checkbox"/> | <input type="checkbox"/> |
| Forgetfulness | <input type="checkbox"/> | <input type="checkbox"/> |
| Confusion Depression | <input type="checkbox"/> | <input type="checkbox"/> |

Female reproductive system

| | | |
|-------------------|--------------------------|--------------------------|
| Vaginal discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| Vaginal bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| Vaginal pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast lumps | <input type="checkbox"/> | <input type="checkbox"/> |

Cardio-vascular/Respiratory system

| | | |
|-------------------------|--------------------------|--------------------------|
| Chest pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain over the heart | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty breathing | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent cough | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing phlegm | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing blood | <input type="checkbox"/> | <input type="checkbox"/> |
| Rapid heartbeat | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Varicose veins | <input type="checkbox"/> | <input type="checkbox"/> |

Gastro-intestinal system

| | HAD | HAVE |
|-----------------------|--------------------------|--------------------------|
| Poor appetite | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive hunger | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty chewing | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty swallowing | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive thirst | <input type="checkbox"/> | <input type="checkbox"/> |
| Nausea | <input type="checkbox"/> | <input type="checkbox"/> |
| Vomiting food | <input type="checkbox"/> | <input type="checkbox"/> |
| Vomiting blood | <input type="checkbox"/> | <input type="checkbox"/> |
| Abdominal pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| Constipation | <input type="checkbox"/> | <input type="checkbox"/> |
| Black stool | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloody stool | <input type="checkbox"/> | <input type="checkbox"/> |
| Hemorrhoids | <input type="checkbox"/> | <input type="checkbox"/> |
| Liver trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Gall bladder problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight trouble | <input type="checkbox"/> | <input type="checkbox"/> |

Eye, Ear, Nose & Throat

| | | |
|-----------------------------------|--------------------------|--------------------------|
| Eye strain | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye inflammation | <input type="checkbox"/> | <input type="checkbox"/> |
| Visual problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear noises | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| Nose pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Nose bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| Nose discharge | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty breathing through nose | <input type="checkbox"/> | <input type="checkbox"/> |
| Sore gums | <input type="checkbox"/> | <input type="checkbox"/> |
| Dental problems | <input type="checkbox"/> | <input type="checkbox"/> |
| Hoarseness | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty speech | <input type="checkbox"/> | <input type="checkbox"/> |

I understand and agree that Alberta Health Care Insurance, W.C.B. and accident insurance policies are an arrangement between an insurance carrier and myself. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services to me will be immediately due and payable.

Signature (If patient is a minor, signature of person legally responsible.) _____

Patient accepted for Chiropractic care

YES

NO

Doctor's Signature _____