Scott Family Chiropractic

Full Name: _____ **Sex:** M/F
Address: _____ **City/Town:** _____
Province: _____ **Postal Code:** _____
Home #: _____ **Business #:** _____ **Cell #:** _____
Email: _____
(We do not trade, sell, or share any of our email addresses)
Date of Birth: _____ **Occupation:** _____
(Month/Day/Year)
Marital Status: _____ **Name of Spouse:** _____
Children: Yes/No **If so, how many?** _____ **Indicate if you are or may be pregnant:** _____
Name(s): _____

How did you hear about our office? _____
What is the main reason for consulting our office today? _____
What goals would you like achieve for your health? _____
When was the last time you felt at your best? _____
Describe the affected areas: _____
_____
When did this problem start? _____
How often does this problem affect you? _____
What makes this problem worse? _____
What makes this problem better? _____
How does this affect your work? _____
How does this affect your family life? _____
How does this affect your ability to enjoy sports, hobbies, life, etc.? _____
Rate your commitment level to assisting us in your care (1-low, 10-high): _____
Rate your commitment level to achieving your health goals (1-low, 10- high): _____
What was the date of your last chiropractic exam? _____
Chiropractor's Name? _____
What is the name of your medical doctor and their contact information?
_____

Personal Habits: *Please specify:* (H - heavy, M - moderate, L - light, or N/A - not applicable)
Alcohol: ___ Coffee/Tea/Cola: ___ Tobacco: ___ Prescription Drugs: ___

List your current medications and what they are for:

_____ _____
_____ _____
_____ _____
_____ _____

How well do you sleep? _____
In what position do you sleep? Back _____ Right Side _____ Left Side_____ Stomach _____

Please list any broken bones, injuries, accidents, falls, or surgery you have ever experienced:
_____
_____
_____

Please check the conditions you experience frequently or are currently experiencing:

HEAD/NECK

Headaches/Migraines: ____
Vision Problems: ____
Earaches/Ear Noises: ____
Ear Infections: ____

RESPIRATORY

Chronic Cough: ____
Shortness of Breath: ____
Recurrent Colds/Infections: ____
Breathing Problems: ____
Allergies/Sinus Problems: ____
Asthma: ____

CARDIOVASCULAR

High/Low Blood Pressure: ____
Heart Disease: ____
Varicose Veins: ____
Poor Circulation: ____
Phlebitis: ____

DIGESTIVE/URO-GENITAL

Difficult Digestion: ____
Liver/Gall Bladder Problems: ____
Constipation: ____
Kidney/Bladder Problems: ____

MUSCLES/JOINTS PAIN OR STIFFNESS

Neck: ____
Shoulders: ____
Right Knee: ____
Left Knee: ____
Other: ____
Mid-Back: ____
Low Back: ____
Upper Back: ____
Right Leg: ____
Left Leg: ____

OTHER CONDITIONS

Insomnia: ____
Weight Loss: ____
Diabetes: ____
Thyroid: ____
Swollen Glands: ____
Arthritis: ____
Weight Gain: ____
Cancer: ____
Nervousness/Anxiety: ____
Menopausal/Menstrual Problems: ____

I have read and agree that all information provided is accurate to the best of my knowledge. I also agree that once explained to me, I will participate in my health care, and the policies and agreements that proceed with my chiropractic care. I understand and agree that health and accident insurance policies are an arrangement between myself and the carrier. I will be provided all the necessary receipts to be reimbursed.

I understand that if I suspend or terminate my care, all fees are due and payable for services rendered. I hereby consent to a preliminary consultation, examination, scans, or other diagnostic testing that will assist the doctor in determining if I am a chiropractic case. If chiropractic care is prescribed, I also agree to chiropractic adjustments, based on my decision to submit to chiropractic care.

I understand and agree that as in all health care, there are some slight risks, and that I have been examined in order to determine if I am at risk. And the doctor has explained all aspects of my care. I will rely on the judgment of the doctor during my course of care. I intend this consent to cover the entire course of my care in this office.

Patient Signature: _____ **Date: _____**
C.H.A. Signature: _____