



PERSONAL INFORMATION

Date: _____

Name: _____ Female Male Care Card # _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Email: _____ Birth Date: _____

Occupation: _____

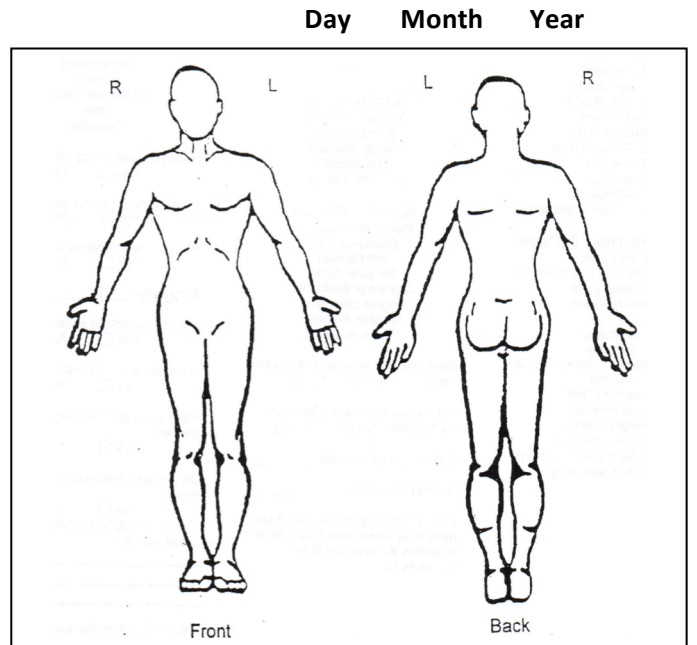
Emergency contact: Name: _____

Phone: _____

Appointment reminder:

- Email
- Text message (Who is your cell phone provider? Bell, Rogers, etc.) _____

How did you hear about us? _____



Please use the diagram at right to indicate the following:

- | | |
|---------------------------|---------------------------|
| Numbness: ===== | Sharp/stabbing: sssss |
| Pins & Needles: ooooo | Dull/aching: >>>> |
| Burning: xxxxx | Stiff/tight: 2222 |

Using the scale, please indicate the severity of your current pain by circling a number:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN

EXTREME PAIN

Reason for appointment: _____ When did this begin? _____

How did this occur? _____

Have you ever had similar problems? Yes No _____

Has the condition improved worsened remained unchanged since it began?

Is this condition related to: Work? Yes No Has your employer been notified? Yes No

Motor vehicle accident? Yes No Date of accident: _____

Claim #: _____ Adjuster: _____

Patient Name: _____

Date: _____

What have you done to help with this condition? _____

Have you had X-rays or other tests (MRI, CT, Ultrasound, blood work etc.) for this condition? Yes No

What tests and when? _____

Can you perform your daily home activities? Yes Yes, only with help Not at all

Can you perform your daily work activities? All activities Only some Not at all

Describe your stress level: None/mild Moderate High

Do you exercise? Daily Occasionally Not at all

Circle the word that best describes the way you feel about your general health:

Excellent Good Acceptable Poor Very poor

What do you hope to achieve from this visit? Check all that apply.

Pain relief Explanation of your condition Exercise to prevent recurrence

Performance care Wellness/maintenance care Other: _____

Have you had any fractures or dislocations? Yes No Body part(s): _____ Date: _____

Have you ever been in a car accident? Yes No Details: _____ Date: _____

Have you ever been hospitalized? Yes No Why? _____ Date: _____

Have you had previous chiropractic care? Yes No Doctor: _____ Date: _____

Please list any previous surgeries, illnesses or injuries: _____

List all medications: (prescriptions, vitamins, herbal supplements, birth control, Aspirin, Advil, Tylenol etc.)

List all known allergies: _____

Have you or a family member ever been diagnosed with or told you have any of the following?

High blood pressure Yes No Family _____

Hardening of the arteries Yes No Family _____

Heart or blood disease Yes No Family _____

Diabetes Yes No Family _____

Tuberculosis Yes No Family _____

Stroke Yes No Family _____

Cancer Yes No Family _____

Osteoporosis (low bone density) Yes No Family _____

HIV/AIDS Yes No

Hepatitis A/B/C Yes No

Are you currently a smoker? Yes No Amount: _____

Did you smoke previously? Yes No Years: _____

Average alcohol intake _____ drinks/day

Average caffeine intake _____ coffee/tea/pop per day

Current sleep quality Poor 1 2 3 4 5 Good

Patient Name: _____

Date: _____

HEALTH STATUS SURVEY

Please circle any conditions that are presently causing you a problem and underline those that have caused you problems in the past.

<p align="center">GENERAL SYMPTOMS</p> <p>Fever Excess sweating/night sweats Loss of consciousness Headache Fatigue Nervousness Weight loss Night pain Loss of sleep</p>	<p align="center">SKIN</p> <p>Rashes Itching Dryness Easy bruising Boils Hives (allergies) Changes in moles or skin markings (size, color, borders, elevation, bleeding)</p>		<p align="center">GENITOURINARY</p> <p>Frequent urination Painful urination Blood in urine Kidney infection Prostate trouble Trouble starting flow Uncontrollable urine flow Bedwetting</p>
<p align="center">NEUROLOGICAL</p> <p>Visual disturbances (blurred, double) Dizziness Fainting Convulsions Problem speaking Problem swallowing Numbness or tingling Clumsiness Weakness</p>	<p align="center">CARDIOVASCULAR</p> <p>High blood pressure Low blood pressure Bleeding disorder Stroke Hardened arteries Heart/blood disease Palpitations Angina Poor circulation Swelling of ankles Varicose veins</p>	<p align="center">RESPIRATORY</p> <p>Asthma Chronic cough Spitting up phlegm Spitting up blood Chest pain Wheezing Difficulty breathing Shortness of breath</p>	<p align="center">GENITOURINARY FOR WOMEN</p> <p>Painful menstruation Excessive flow Hot flashes Irregular/absent cycle Cramping/backache Vaginal discharge Nipple discharge Swollen Breasts Lumps in breast Menopausal symptoms Pregnancy complications/miscarriage Pregnant? Y / N Week?</p>
<p align="center">EYES/EARS/NOSE/THROAT</p> <p>Failing vision Eye pain Failing hearing Earache Ring/buzz in ears Frequent colds Sinus infection Enlarged thyroid Enlarged glands Hoarseness Nasal drainage Nosebleeds</p>	<p align="center">MUSCLE & JOINT</p> <p>Neck pain Back pain Tailbone pain Shoulder pain Arm/forearm/elbow pain Wrist/hand pain Hip/leg pain Knee pain Ankle/foot pain Swollen joints Spinal curvature Arthritis</p>		<p align="center">GASTROINTESTINAL</p> <p>Poor appetite Indigestion/heartburn Excess hunger Belching/gas Nausea/vomiting Constipation Diarrhea Hemorrhoids (piles) Blood in stool Gallbladder trouble Jaundice Ulcer</p>

WRITTEN CONSENT TO NOTIFY FAMILY PHYSICIAN OF CHIROPRACTIC CARE

At Bluebird Sport & Spine, we strive to maintain open communication and professional relationships with other health care providers. In order to provide updates to your family doctor regarding your care, we need to obtain written consent from you as our patient. Please fill in the information below so we can inform your doctor about your diagnosis, treatment, and progress at our clinic.

Dated this _____ day of _____, 20____.

Family Physician's Name: _____ Phone: _____

Patient Signature: _____ Witness Signature: _____

Patient Name: _____ Witness Name: _____

(please print)

(please print)