Innovation Wellness & Massage Ltd.

Patient Name: Dr./ Mr./ Mrs./MS. _____

Last **Legal First** **Middle Initial**

Name you prefer to be called: _____ **DATE:** _____

Home #: _____ **Work #:** _____ **Cell #:** _____

E-mail: _____ Do you want your appointment reminders emailed to you? ☐Yes ☐No

Address: _____ **City:** _____ **Prov:** _____

Postal Code: _____ **Age:** _____ **Birthdate (mm/dd/yy):** _____ **Sex:** _____

Patients Employer: _____ **Occupation:** _____

Phone #: _____ **ext.:** _____

Saskatchewan Hospitalization # : _____

PERSONAL HEALTH HISTORY

Height: _____ **Weight:** _____

Have you had previous chiropractic care? Yes/ No **By Whom?** _____ **When:** _____

Have you had previous Acupunture Care? Yes/No

Who referred you to our practice? _____

Medical Doctor: _____ **Location:** _____ **Last time you have seen him/ her:** _____

When was your last physical exam? _____

Results? _____

Have you ever had x-ray of your spine? When? _____ **Where?** _____ **Results?** _____

Are you, or might you be pregnant? No/ Yes

Please list ALL current medication and conditions taken for: _____

_____

Please list all current vitamin/mineral supplements: _____

_____

List any known allergies: _____

If you smoke or have ever smoked, describe how much, and for how long: _____

Please list and describe all significant previous injuries (sprains, fractures, accidents, etc.): _____

_____

Have you had issues with your blood pressure or blood clotting? Yes/ No

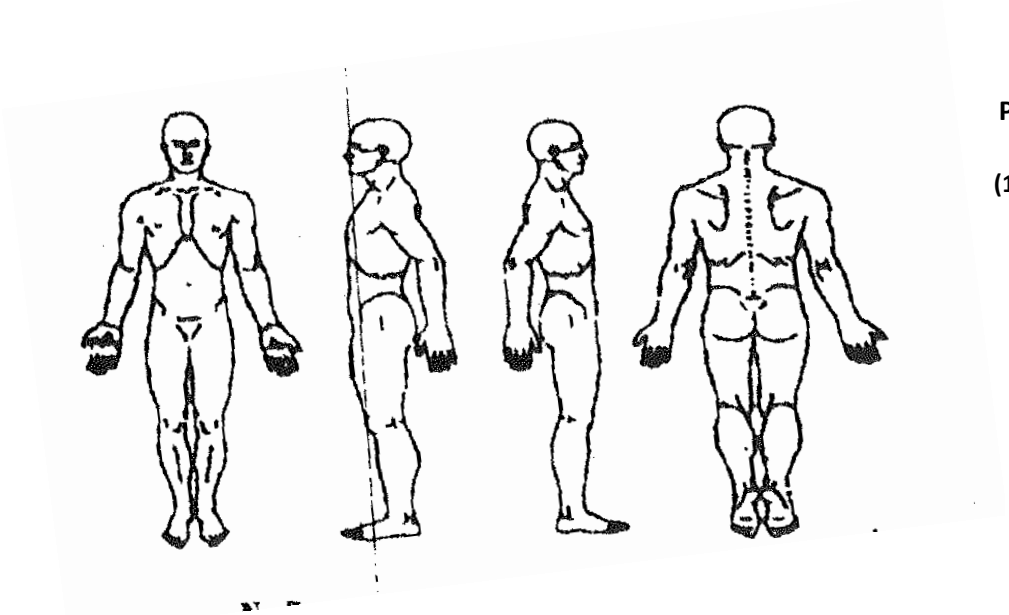
How many days a week do you exercise? 0 1 2 3 4 5 6 7 **How would you rate your stress levels? No stress 1 2 3 4 5 6 7 8 9 10 High Stress**

Chief Complaint

1. **Are your present symptoms or conditions related to, or the result of an auto accident, work- related injury? Yes/ No**
2. **What is your chief complaint or reason for your appointment? Please describe: :** _____
   _____
   _____
3. **When did your condition first begin? Year:** _____ **Month?** _____ **Day?** _____
4. **Cause of condition (circle) : auto accident work injury sudden trauma reoccurrence repetitive trauma unknown/ gradual other explain:** _____
5. **Have you had anything like this before? Yes/ No When?** _____
6. **How often does the problem re- occur?** _____
7. **Is the pain (circle) constant, on & off, usually lasting:** _____ **minutes** _____ **hrs** _____ **days**
8. **Lately, has the pain been (circle): getting better getting worse staying the same**
9. **Does the pain radiate anywhere? To where:** _____
10. **What makes it feel better?** _____
11. **What makes it worse?** _____
12. **If you have seen another professional for the problem or done any self-care, describe the type of treatment AND results:** _____
    _____
13. **At what time of day, week, or setting is your pain worst?** _____
14. **Please list any activities you are unable to perform/ have not performed due to the pain, or for fear of making the pain worse:** _____
    _____
15. **What else would you like the Dr. to know about you and/ or your condition:** _____
    _____

16. **CIRCLE HOW YOU WOULD DESCRIBE THE PAIN: Sharp/ Stabbing Dull/Ache Pins & Needles Numbness Burning**

PLEASE MARK THE AREA(S) ON THE DIAGRAM WHERE YOU ARE HAVING THE PROBLEM(S):



Please Circle Your Level of Pain Below

(1= minimal pain; 10= worst pain imaginable)

PAIN CURRENTLY

1 2 3 4 5 6 7 8 9 10

PAIN AT ITS WORST

1 2 3 4 5 6 7 8 9 10

PAIN TYPICALLY

1 2 3 4 5 6 7 8 9 10