Aspire Chiropractic & Massage

New Patient Information

Personal Information

Name:_________________________________ Home#: ________________ Work#: ______________ Cell#:________________

Mailing Address:____

City: ________________ Province: _______________ Postal Code: ____________ AHC# ______________________

Birth date (mm/dd/yyyy): _____________Age_____ Sex: M / F / X Marital Status: ________________

Occupation:__________________________ E-mail Address: ____

Who may we thank for referring you to our office?____

Is this injury the result of a motor vehicle accident or work-related accident?

If Yes, please list:____

Have you had previous chiropractic care? ☐Yes ☐No Doctor's name: ____________________ How long ago?_________

Have you received X-rays in the last 2 yrs.? ☐Yes ☐No Area x-rayed____

Name of Family Medical Doctor__________________________ Others seen for this condition__________________________

Emergency Contact Name: _____________________________ **Emergency Contact Number**: _________________________

Please check any of the following that currently apply to you.

☐Sleeping Problems	☐Dizziness	☐Headaches	☐Fevers
☐Bowel Problems	☐Hypoglycemia	☐Heartburn	☐Chronic Fatigue syndrome
☐Nervousness	☐ADHD	☐Hot Flashes	☐Depression
☐High Blood Pressure	☐Difficulty Breathing	☐Seizures	☐TMJ/Jaw Pain
☐Ulcers	☐Poor Concentration	☐Menstrual Pain	☐MS
☐Frequent Colds	☐Problem Urinating	☐Mood swings	☐Fibromyalgia
Pins & Needles in: ☐legs/feet ☐arms/hands	☐Lack of / low energy	Numbness in: ☐Feet/Toes	☐Auto-immune system disorders
	☐Poor Awakening	☐Hands/fingers	☐Epstein-Barr syndrome
☐Heart Palpitations	☐Buzzing/ringing ears	☐Bed Wetting	☐Ear Aches
☐Cold hands/feet	☐Loss of Taste/Smell	☐Panic Attacks	☐Loss of Balance
☐Neck Pain/stiffness	☐Irritability	☐Allergies	☐Rheumatoid Arthritis

Your Injury History

1. What is your major reason for consulting our office? ____

2. How long has this been going on? ☐ Days ☐ Weeks ☐ Months ☐ Years

   How did it originally occur? ____

3. What specific life activities does it interfere with (work, sleep, leisure, etc.)? ____________________

   Has it become worse recently? ☐ Yes ☐ No ☐ Same ☐ Better ☐ Gradually Worse

   If yes, when and how? ____

4. How frequent is the condition? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night Only

5. Is there anything you can do to relieve the problem? ☐ Yes ☐ No

   If yes, describe: ____

   If no, what have you tried to do that has not helped? ___________________________________

6. What makes the problem worse? ☐ Standing ☐ Sitting ☐ Lying ☐ Bending ☐ Lifting ☐ Twisting

   Other ____

7. Describe the pain: ☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing

   Other ____

   Does the pain travel or radiate? ☐ Yes ☐ No If Yes, where? ________________________

8. Are there other unrelated health problems? ☐ Yes ☐ No — If yes, describe ______________________________

9. Have you had any broken bones? ☐ Yes ☐ No — Please list ______________________________

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? ☐Yes ☐No If yes, please explain ____________________

11. To your knowledge, is there a family history of cancer, stroke, diabetes, heart disease or a spinal condition? ☐Yes ☐No If yes, please explain ____

____

11. List any medications you are taking: ____

Please place an "X" and assign a number 0-10 on the line below to indicate level of problem.

NO SYMPTOMS 0 I---I 10 EXTREME SYMPTOMS

Your Health Profile

Spinal subluxations have a significant impact on your health and well-being. Please answer the following important questions to the best of your ability, in as much detail as possible.

Physical Stress

☐Yes ☐No Have you ever been involved in a motor vehicle accident (even if you were not injured)? If yes, please describe: ____

☐Yes ☐No Have you had any falls or accidents (especially hard falls, sports/car accidents, concussions, broken bones, etc.)? If yes, please list all:_______________________________________

☐Yes ☐No Do you currently play any sports?

☐Yes ☐No Have you had any sports injuries?
If yes, please describe: ____

☐Yes ☐No Were you under regular Chiropractic care as a child?

☐Yes ☐No Does your job require lifting, repetitive motions, or excessive standing or sitting?

☐Yes ☐No Have you had any surgeries? Please list all:____________________________________

Nutritional Stress

☐Yes ☐No Do you take a multivitamin? Which brand? ___________________________

☐Yes ☐No Do you supplement with a greens powder? ___________________________

☐Yes ☐No Do you take omega 3 / fish oil / cod liver oil? _________________________

☐Yes ☐No Do you take 4,000-5,000 IU of Vitamin D daily? ______________________

☐Yes ☐No Do you take a probiotic? ____

Emotional Stress

On a scale from 1 (best) → 10 (worst), rate your current stress level of the following:

Work ________ Home ________ Financial ________ Other ________

Please describe the following as either poor, fair, good or excellent:

Diet ________ Exercise ________ Sleep ________ General Health ________

The personal information on this form is collected under the Health Information Act Guidelines and serves only to identify this information as belonging to the patient.

Doctor's Signature ____ Date ______________________________