Tri-City Natural Health Care Centre
Chiropractic ▲ Nutrition ▲ Orthotics ▲ Acupuncture ▲ Massage Therapy

Confidential Patient Record

Name:		Today's Date: *D/M/Y*
Address:		Postal Code:
City:	Date of Birth *D/M/Y*	Occupation:
Work Phone # Work Fax #	Home Phone #	Cell Phone #
Marital Status: *Single Married Divorced Widowed*	Spouse's Name:	Spouse's Occupation:
Do you have children? *Yes No* Family Doctor(s):	What are their names?	E-mail Address:
Who referred you to this office?	Have you ever been to a chiropractor? *Yes No*	If yes, who and when?

Health Survey

Present complaint(s):					
Does this problem interfore with (circle all that apply):	*Ability to work*	*Hobbies/sports*	*Ability to sleep*	*Famly/social time*	
Do you have or are currently working on other health goals?					
Do you take medication, e.g. Aspirin, Birth Control, Prescription Drugs? *Yes No*				If yes, what and how much?	
Do you take any nutritional supplements? *Yes No*				If yes, what and how much?	
Have you had any accidents, e.g. car accidents, bad falls (what and when)?					
Have you ever broken any bones (what and when)?					
Do you have a family history of (circle all that apply)? *If yes, who has/had and are they still alive/when did they pass away?*	*High Cholesterol* *Stroke*	*High Blood Pressure* *Cancer*	*Heart Disease* *Diabetes*		
Do you smoke? (please circle one)	*No*	*Occasionally*	*1/4 pack/day*	*1/2 pack/day*	*3/4 pack/day* *1 pack/day* *1+ packs/day*
Do you exercise? (please circle one)	*Yes*	*No*	*If yes, what do you do? How many times per week?*		
Do you eat fast food? (please circle one)	*Yes*	*No*	*If yes, how many times per week? 1 2 3 4 5 6 7 8 9 10*		
Do you drink alcohol? (please circle one)	*Yes*	*No*	*If yes, how many drinks per week? Infrequent 0-5 5-10 10-15 15-20 20-25 25+*		
Do you eat three meals a day (B, L, D)?			*No* *Once in a while* *Often* *Always*		
Sleep position and habits (circle all that apply)	*Back* *Trouble staying asleep*		*Stomach* *Trouble getting to sleep*	*Side* *Frequent urination at night*	*Restless*

Patient History Form

Name: _____ **CC:** _____

ONSET, PRIOR, PROVOCATIVE, PERSISTENCE, PROGRESSION/PALLIATIVE, QUALITY, REFERRED, RADIATING, SEVERITY, TEMPORAL, OTHER/ASSOC SXS, SURGERIES, HOSPITALIZATIONS, FALLS/MVAS, FRACTURES, MEDS/NUT, FAMILY HX

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