Kilworth Family Chiropractic Centre

Dr. Jeffery Campbell
CHIROPRACTOR/ACUPUNCTURE

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The purpose of our office is to restore and maintain the health of our patients through natural, chiropractic methods.

Please complete this confidential health questionnaire fully and accurately. The more we know about the overall picture of your health, the better we will be able to help you.

Doctors of Chiropractic are trained to detect and correct vertebral subluxations. Please respond to this questionnaire thoroughly to help us determine potential causes and effects of subluxations in your case.

If you have any questions, please don't hesitate to ask us!

Experience with Chiropractic Care

Who referred you to this office? _____

Have you ever been adjusted by another Chiropractor?

_____ Yes _____ No

Reasons for those visits? _____

_____

Were x-rays taken? _____ Yes _____ No

Chiropractor's Name: _____

Approximate date of last visit: _____

Patient Information

Name _____

Street Address _____

City _____ Postal Code _____

Telephone

Home _____ Cell _____

Work _____ Ext _____

Email _____

Gender _____ Male _____ Female

Birthdate (dd/mm/yy) _____ Age _____

Height _____ Weight _____

Marital Status _____ Single _____ Married _____ Separated

_____ Divorced _____ Widowed _____ Common-Law

Name of Spouse/Significant other _____

# of children _____

My occupation _____

Employer _____

Goals for My Care

People see chiropractors for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others for the correction of whatever is malfunctioning in their bodies. Your Doctor will weigh your needs and desires when making recommendations for care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

_____ Relief Care - symptomatic relief of pain or discomfort

_____ Corrective Care - correcting and relieving the cause of the problem as well as the symptoms

_____ Comprehensive Care - bring whatever is malfunctioning in the body to the highest state of health possible with chiropractic adjustments

_____ I want the Doctor to select the type of care appropriate to my health status

_____

(Signature) (Date)

Family Health History

Family members with diagnosed health problems _____

_____

History of Chemical and Personal Stress

Medications I am presently taking

- ☐ Painkillers _____
- ☐ Anti-inflammatories _____
- ☐ Muscle relaxants _____
- ☐ Blood pressure medication _____
- ☐ Stimulants, anti-depressants _____
- ☐ Tranquilizers, anti-anxiety _____
- ☐ Blood thinners _____
- ☐ Birth control pills _____
- ☐ Other _____

_____

Health Habits

	Heavy	Moderate	Light	None
Tobacco	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Prescription Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Personal Stress Levels

Past	☐	☐	☐	☐
Present	☐	☐	☐	☐

I hereby authorize the doctors in this clinic to examine my condition and render care as deemed necessary.

In the event that X-rays are necessary in my case, I understand and agree that X-rays taken in this clinic are the property of Kilworth Family Chiropractic Centre, and will remain in this clinic where they can be reviewed for me by the doctors.

I have listed below an emergency and/or alternate contact with whom this office may communicate, if I cannot be contacted personally, or in the case of an emergency. Under such circumstances only, this office has my consent to identify me as a patient to the contacts named below.

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that fees for professional services are due when rendered. I understand that if I suspend or terminate my care, any fees for professional services rendered will become immediately due and payable.

(Check if applicable) ☐ I have health coverage and/or accident insurance through _____
I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself.

SIgnature (I have read and understand the above) Date

Alternate Address
☐ Permanent ☐ Temporary ☐ Parent ☐ Not Applicable

Name _____
Address _____ Unit# _____
City _____ Prov _____
Postal _____ Telephone _____

Emergency Contact
Name of a relative or close friend not living at my own address

Name _____
Address _____ Unit# _____
City _____ Prov _____
Postal _____ Telephone _____

What is the purpose of this appointment?

Describe the purpose of this visit _____

_____

Is the purpose of this appointment related to:

___ Work ___ Stress ___ Sports ___ Auto ___ Fall ___ Chronic Discomfort ___ Repetitive Trauma ___ Check-Up ___ Other

Please explain: _____

(For a specific chief complaint, please complete the section immediately below)

How long have you had this condition? _____ Have you had this or similar conditions in the past? (When?) _____

What activities aggravate you condition? _____

Has this condition _____ gotten worse _____ stayed constant _____ comes and goes

Does this condition interfere with ___ Work ___ Sleep ___ Daily Routine ___ Childcare Responsibilities ___ Sports ___ Other (*explain*)

_____

Have you seen any other health care providers for diagnosis or management of this condition? _____ Yes _____ No (if yes explain)

Practitioner's Name _____

Type of Care _____

Date _____ Results _____

Practitioner's Name _____

Type of Care _____

Date _____ Results _____

Are you seeking chiropractic care _____ as primary intervention _____ in conjunction with other interventions _____ as a last resort

My Health Conditions

Please check each of the disease or conditions that you have now or have had in the past. While some conditions may seem unrelated to the purpose of this appointment, they can affect diagnosis, care plan, and the possibility of being accepted for care or referred to another practitioner, if necessary.

General
___ Allergy
___ Convulsions
___ Dizziness
___ Fatigue
___ Headache
___ Loss of sleep
___ Loss of weight
___ Anxiety/depression
___ Numbness
___ Cancer
___ Diabetes
___ Thyroid problems
___ Epilepsy
___ Hyperactivity

Muscle and Joint
___ Arthritis
___ Hernia
___ Low back pain
___ Neck pain
___ Pain between shoulder blades

Other (not listed)

Numbness or pain in:
___ Shoulders
___ Upper arms
___ Hands
___ Legs
___ Feet
___ Poor posture
___ Swollen joints
___ Gout
___ Polio

Gastro-intestinal
___ Constipation
___ Diarrhea
___ Digestive dysfunction
___ Gallbladder trouble
___ Hemorrhoids
___ Liver trouble
___ Ulcers

Eyes, Ears, Nose, Throat
___ Asthma
___ Frequent colds
___ Crossed eyes
___ Deafness
___ Ear infections
___ Ringing in ears
___ Eye pain
___ Vision problems
___ Nasal obstructions
___ Sinus infections

Cardio-Vascular
___ High blood pressure
___ Low blood pressure
___ Poor circulation
___ Irregular heart rate
___ Ankle swelling
___ Anemia
___ Arteriosclerosis
___ Stroke

Respiratory
___ Chest pain
___ Chronic cough
___ Irregular breathing
___ Wheezing
___ Emphysema

Genito-Urinary
___ Bed-wetting
___ Painful urination
___ Prostate trouble
___ Blood in urine
___ Venereal disease

Women Only
___ Menstrual cramps
___ Excessive menstruation
___ Irregular cycle
___ Hot flashes

Are you pregnant? __ yes __ no

Other (not listed) ____

Sources of Spinal Stress

To help us determine the cause of your problem, please indicate, on this page, potential sources of spinal trauma.

General Physical Trauma

Falls

(Details and Dates)

- ☐ as infant or child _____
- ☐ down stairs _____
- ☐ on ice _____
- ☐ sports impacts _____
- ☐ physical fight _____
- ☐ other _____

Primary Daily Activities

☐ sitting ☐ standing ☐ walking ☐ desk work ☐ telephone
☐ driving ☐ manual repetitive work ☐ heavy lifting

Exercise

☐ heavy/daily ☐ moderate/recreational ☐ periodic

Describe _____

Sports and Leisure

Were you, or are you, active in any sports? ☐ Yes ☐ No

Describe _____

Have you been hurt or injured in any of these activities

Birth

With respect to your own birth process, check all that apply:

- ☐ Natural
- ☐ Premature
- ☐ Breech
- ☐ Forceps
- ☐ Vacuum extraction
- ☐ Epidural/drug-induced
- ☐ Cesarean section
- ☐ Cord around neck
- ☐ Prolonged delivery
- ☐ Pulling/twisting by delivery doctor

Did the mother sustain any falls, accidents, or injuries during pregnancy?

☐ Yes ☐ No ☐ Unknown

Conditions experienced immediately following birth:

☐ Jaundice ☐ Feeding problems ☐ Respiratory problems
☐ Displaced or broken bones ☐ Other _____

Birth location

☐ Home ☐ Birthing centre ☐ Hospital ☐ Other _____

Auto Accidents

Have you ever, even as a passenger, even if you did not think you were hurt, been involved in a car accident or near collision?

☐ Yes ☐ No

If yes, please indicate approximate dates and severity below:

_____

_____

If your chief complaint is in direct response to a motor vehicle accident, please notify our staff, as we will require a separate questionnaire to document your accident and injury.

With respect to the questions below, please provide details where applicable, including dates:

Have you ever been knocked unconscious? ☐ Yes ☐ No _____

Have you ever used crutches, a walker, or a cane? ☐ Yes ☐ No _____

Have you had any broken bones? ☐ Yes ☐ No _____

Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? ☐ Yes ☐ No

_____

Have you had extensive dental or orthodontia work performed? ☐ Yes ☐ No _____

Sprains, strains, dislocations and years: _____

_____

Surgical operations and years: _____

_____

Have you ever been hospitalized for any other reason? ☐ Yes ☐ No _____