



TAUNTON CHIROPRACTIC
AND HEALTH CENTRE

File# _____

Name: _____ Date: _____

Sex: Male Female Date of Birth(DD/MM/YY): _____

Address: _____ City: _____ Postal Code: _____

Phone #: (Home) _____ (Work) _____

Emergency Contact Name and Phone Number: _____

Email Address: _____

Family Doctor Name and Address: _____



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Date of Last Appointment or physical: _____

Occupation: _____ What do you do mostly? (sit/stand/etc.) _____

Height: _____ Weight: _____

How did you hear about our clinic? _____

Please describe your present complaint: _____

When did it occur? _____ How did it occur? _____

Have you received any treatment for this condition, and if so what kind of treatment?

Has any treatment helped? _____

Have you ever had a similar problem to your current complaint? _____

Were X-rays taken? YES NO

Have you been to a chiropractor before? Y / N When was your last treatment? _____

Was this an injury that occurred at work? Y / N Was it reported? Y / N

Was this an injury as a result of a car accident? Y / N Is there a claim pending? Y / N

Do you currently smoke? Y / N

How often do you exercise and what type of activity is it? _____ times/week

Any Prior Surgery? _____

Prior Hospitalizations? _____

Have you broken any bones? _____

Do you currently take any prescription or over the counter medications or vitamins/nutritional supplements? Y / N

Specify: _____

Females Only:



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Date of last menstrual period? _____ Are you currently pregnant? Y / N

Have you ever taken birth control pills? _____

Are you currently taking birth control pills? _____

How many children do you have? _____

How many pregnancies? _____

What would you like to achieve by coming to our clinic? _____

(Our primary goal is always to work toward the resolution of your condition as quickly as possible!)

Do you have any concerns about the therapy that you would like us to address before we begin treatment? _____

(We believe that good client communication is essential and we always want to know your perspectives – positive or negative.)

I hereby authorize Taunton Chiropractic and Health Centre, with my prior knowledge, to release to or obtain any health information from my other healthcare providers as may be required for the management of my case.

I have read and understand the Taunton Chiropractic and Health Centre fee schedule and cancellation policy. I am aware that if insurance claims are being submitted on my behalf that I am responsible for any outstanding balance not covered by my insurance policy.

Client Signature: _____

Family Health History

Have your grandparents, parents or siblings ever been diagnosed with any of the following?



- High blood pressure
- Heart disease
- Stroke
- Diabetes (Type I or Type II)
- Thyroid / Hormone problems
- Breathing or lung problems

- Rheumatoid Arthritis
- Osteoarthritis
- Neurological problems
- Cancer
- Kidney Disease
- Other specify:

Client Health History

Please **check anything which is causing you problems right now**

Please **circle anything which has been a problem in the past**

- Persistent fatigue
- Headache
- Fever
- Sweats
- Fainting
- Dizziness
- Loss of Sleep
- Numbness
- Tingling
- Weight Loss
- Pain

- Chronic Cough
- Spitting up Blood
- Chest Pain
- Difficulty Breathing

- Rashes
- Itching
- Bruise Easily
- Skin Dryness
- Boils
- Hives (allergy)

- Back Ache
- Swollen Joints
- Foot Pain L / R
- Shoulder Pain L / R
- Elbow Pain L / R
- Wrist Pain L / R
- Hand Pain L / R
- Hip Pain L / R
- Knee Pain L / R
- Arthritis
- Weakness
- Loss of Strength
- TMJ Problems L / R

- Blurred Vision
- Double Vision
- Deafness
- Earache
- Asthma
- Frequent Colds
- Sinus Problems
- Enlarged Glands
- Speech Problems
- Difficulty Swallowing
- Seizures/Epilepsy
- Bleeding Disorder
- High Blood Pressure
- Stroke
- Varicose Veins
- Hardening of Arteries
- Swelling of Ankles
- Heart or Blood Disease
- Heat/Cold Intolerance
- High Cholesterol

- Ulcer
- Diabetes
- Poor Appetite
- Indigestion
- Excessive Hunger
- Belching or Gas
- Nausea
- Vomiting
- Pain Over Stomach
- Constipation
- Diarrhea
- Hemorrhoids
- Jaundice
- Gallbladder Problem
- Bed Wetting
- Frequent Urination
- Difficulty Urinating
- Blood in Urine
- Kidney Infection

- Breast Lump/Pain
- Severe Menstrual Cramps
- Hot Flashes
- Irregular Cycle

Name: _____

Date: _____

INDICATE THE SEVERITY OF YOUR SYMPTOMS



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5

10



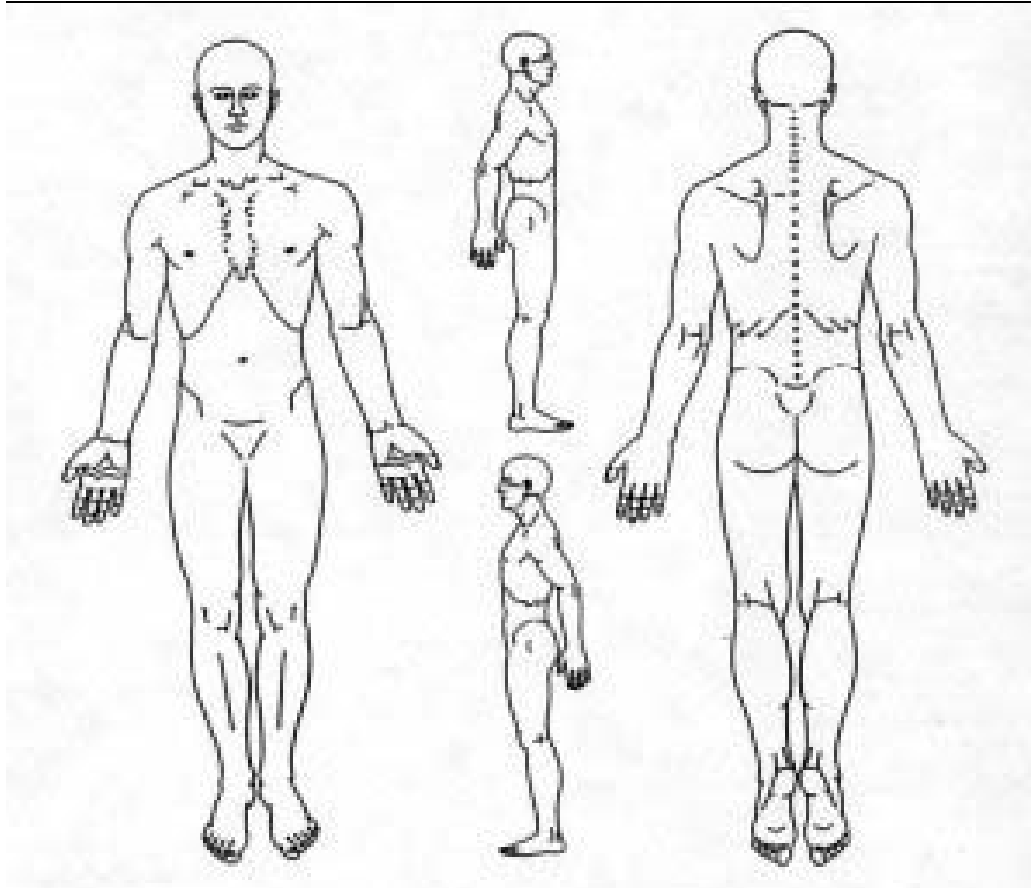
TAUNTON CHIROPRACTIC AND HEALTH CENTRE

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No Symptoms

Extreme Symptoms

PLEASE CIRCLE YOUR AREA OF COMPLAINT AND INDICATE THE TYPE OF SYMPTOM AND IT'S SEVERITY.



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STIFFNESS * * * * *

STABBING 2 2 2 2 2 2

NUMBNESS + + + + +

PINS & NEEDLES 0 0 0 0 0 0