CONFIDENTIAL PATIENT INFORMATION

Welcome to our office! Please complete all questions. Thank you.

Name:_____ Sex: M__ F__
Address:_____Apt. #_____
City:_____ Province:_____Postal Code:_____
Home Phone:( )_____Bus. Phone:( )_____ext____
Mobile: ( )_____Email Address_____
Date of Birth:_____/d_____/m_____/y Marital Status: M S W D C
Occupation:_____Spouse's Name:_____
Children's Names and Ages:_____
_____
Who may we thank for referring you?_____
Favourite Hobbies or Interests:_____
Previous Chiropractic Care? Y N If yes, name of Doctor, and date of last visit:_____

Current health concerns for consulting our office:
1._____ For how long?_____
2._____ For how long?_____
3._____ For how long?_____
Have you had the same or similar problem(s) before?_____
If yes, for how long?_____
Other doctors you have seen for this problem:_____
Have you had X-rays taken previously? Where, When?_____
Surgeries you have had:_____
Please list any fractures or dislocations you have had, date & area of body:_____
Medications you are currently taking:_____
Do you suffer from allergies? Please list:_____
Have you ever been diagnosed with cancer?_____ If so, what kind?_____

I hereby give my consent for Dr. John Noble/Dr. Mark Fera to conduct an examination and X-ray today.

_____ _____
PATIENT OR GUARDIAN SIGNATURE DATE

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Smallpox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

INTAKE
- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD IN THE PAST SIX MONTHS:

MUSCULO-SKELETAL CODE
- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing/Clicking Jaw
- ☐ General Stiffness

NERVOUS SYSTEM CODE
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

GENERAL CODE
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTROINTESTINAL CODE
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE
- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Programs
- ☐ Irregular Heartbeat
- ☐ Heart Programs
- ☐ Lung Programs/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT CODE
- ☐ Vision Programs
- ☐ Dental Programs
- ☐ Sore Throat
- ☐ Earaches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

FEMALES ONLY:

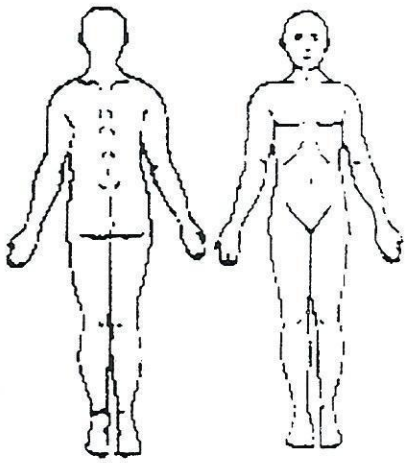
When was your last period?

_____

Are you pregnant?
☐ Yes ☐ No

MALE/FEMALE CODE
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

Please outline on the diagram the area of your discomfort



FAMILY HISTORY

The following members have the same or similar problem(s) as I do:
- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

DO NOT WRITE BELOW THIS LINE

CHIROPRACTIC ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

_____
Doctor's Signature

P.O.M.