CONSULTATION HISTORY

Today's Date: _____

Name: _____ Date of Birth: _____/_____/_____
Address: _____ P.C._____ DD MM YYYY
Home Phone # ___(___)_____ Cell Phone # ___(___)_____ Age:_____
Occupation: _____ Employer: _____
Work Phone # ____(___)_____ Can we contact you at work? Yes ( ) No ( )
Email address: _____ Social Insurance Number _____
Marital Status: _____ Number of Children: _____
Referred by: _____ Have you seen one of our ads? Yes ( ) No ( )

PLEASE FILL IN THE APPROPRIATE SPACES (All information you give is confidential):

1. What is your major complaint? _____
   Other complaints _____
2. What have you heard about chiropractic? _____
3. Which of your complaints bother you the most? _____
4. How long have you had the complaint(s)? _____
5. Prior to the problem beginning, did you ever have an earlier problem that was the same or similar?
   _____ When?_____
6. Did it appear slowly or immediately? _____
7. Does anyone else in your family have this problem or a similar one? _____
   _____
8. Have you lost work days? Yes ( ) No ( ) How many? _____
9. Is this condition a: Work accident ( ) Auto accident ( ) Date of accident: _____
10. How often does it bother you? _____
11. Is this condition interfering with your: Work ( ) Sleep ( ) Daily routine ( )
12. When it is at its worst, how does it feel? _____
13. What have you done to aggravate the problem and/or what have you failed to do that would have helped to get rid of it? _____
    _____
14. When was the last time you really felt good? _____
15. When did you last see a chiropractor? _____ Dr's Name: _____
16. If this problem was left unhandled for five years, how do you think it would affect you?
    _____
17. Have you ever worn: Heel lifts ( ) Arch Supports ( ) When? _____
18. Dental visits: Every 6 months ( ) Yearly ( ) Toothache or Emergencies only ( ) Dentures ( )
19. Are you committed to getting rid of not only your symptom(s) but what caused it? Yes ( ) No ( )
20. Tell me about your family health history: _____
    _____
    _____
    _____
    _____

Thompson Chiropractic
Simcoe office (519) 426-8330
Waterford office (519) 443-6663

PLEASE MARK PAST CONDITIONS WITH (0) OR PRESENT CONDITIONS WITH (X):

_____ Fractured Bones
_____ Auto Accidents
_____ (a) _____ 0-1 years ago
(b) _____ 1-5 years ago
(c) _____ More than 5 years ago
_____ Other Accidents / Falls
_____ Knocked Unconscious
_____ Back Curvature
_____ Mental or Emotional Disorders
_____ Arthritis
_____ Diabetes
_____ Swollen or Painful Joints
_____ Convulsions / Epilepsy
_____ Skin Problems
_____ Itching
_____ Bruise Easily
_____ Cancer
_____ Frequent Colds/Flus
_____ Nervousness
_____ Tension
_____ Depressed
_____ Irritable
_____ Anemia
_____ Excess Sweating
_____ Tremors
_____ Light Bothers Eyes
_____ Under Stress
_____ Crave Sweets or Salt
_____ Eating Disorders
_____ Trouble Concentrating
_____ Loss of Memory
_____ Ear Infections

_____ Learning Disability
_____ Mistake sidedness (R. from L.)
_____ Stutter
_____ Dyslexia
_____ Mood Changes
_____ Lose Temper Easily
_____ Headache
_____ Neck pain or stiff R.L.
_____ Numbness, tingling, or pain in arms hands, fingers R.L.
_____ Jaw Pain or Click (TMJ) R.L.
_____ Head seems too heavy
_____ Head & Shoulders feel tired
_____ Difficulty in excessive (standing walking, sitting, riding, bending, lifting, twisting, household duties)
_____ Shoulder pain R.L.
_____ Dizziness
_____ Ringing in ears R.L.
_____ Hearing Loss R.L.
_____ Fainting
_____ Loss of balance
_____ Blurred or double vision R.L.
_____ Upper back pain or stiffness R.L.
_____ Mid back pain or stiffness R.L.
_____ Pain with cough, sneeze, or strain at stools
_____ Hip pain R.L.
_____ Foot trouble L.R.
_____ Chest Pain
_____ Asthma
_____ Difficulty Breathing
_____ Detached Retina

_____ Wheezing
_____ Heart Problems
_____ Stroke
_____ High or low blood pressure
_____ Varicose Veins
_____ Liver Trouble
_____ Gall Bladder Trouble
_____ Digestive Problems
_____ Excessive Gas
_____ Belching/bloating after meals
_____ Heartburn
_____ Ulcers
_____ Diarrhea / Constipation
_____ Colon Trouble
_____ Hemorrhoids
_____ Prostate problems
_____ Impotence
_____ Kidney Stones
_____ Kidney Trouble
_____ Frequent Urination
_____ Discharge
_____ Menstrual problems / PMS
_____ Menopausal problems
_____ Breast lumps, soreness, discharge
_____ Pregnant (now)
_____ Hepatitis
_____ Venereal Disease
_____ AIDS / HIV
_____ Trouble Sleeping
_____ Lung Problems
_____ Knee Pain
_____ Glaucoma

Current Medications:

_____

_____

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RENDERED UNLESS SPECIAL ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

Patient Signature: _____ Date: _____

Doctor's Signature: _____, D.C.