Progressive Family Wellness Centre

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www.progressivewellness.ca

CONFIDENTIAL APPLICATION FOR CARE

Personal Information

Name: Date:

Address: Home Phone:

City, Province, Postal Code: Work Phone:

Email Address: Cell Phone:

Best time/number to contact you:

Occupation: Employer:

Date of Birth: Age: Gender: ☐ Male ☐ Female ☐ Non-binary Height: Weight:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Common Law/Serious Relationship ☐ Engaged

Name of Spouse / Significant Other:

Number of Children: Names & Ages:

Emergency Contact: Phone Number: Relationship:

Do you have extended health coverage? ☐ Yes ☐ No Annual Chiropractic Coverage Amount: Orthotics: ☐ Yes ☐ No

Previous Chiropractic Care? ☐ Yes ☐ No Doctor's name: Family Physician:

Who may we thank for referring you?

History of Complaint

Please identify the condition(s) that brought you into this office: Primary:

Secondary: Third: Fourth:

On a scale of **0 -10** with **0** being no pain and **10** being the worst pain, rate your above complaints by ***entering the number:***

Primary Complaint: When did the problem begin?

Secondary Complaint: When did the problem begin?

Third Complaint: When did the problem begin?

Fourth Complaint: When did the problem begin?

Primary Complaint Details

When is it at its worst? ☐ AM ☐ Mid Day ☐ PM ☐ Late PM

How long does it last? ☐ Constant ☐ It Comes & Goes During the Day ☐ It Comes & Goes Throughout the Week

What aggravates your symptoms? ☐ Lying Down ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking ☐ Nothing

What relieves your symptoms? ☐ Rest ☐ Ice ☐ Heat ☐ Massage ☐ Movement ☐ Medication ☐ Nothing

Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Burn ☐ Throb ☐ Spasm ☐ Numb ☐ Tingling ☐ Shooting ☐ Sore ☐ Stabbing

Have you experienced any travelling pain? (eg. pain that begins in one area & travels to another) ☐ Yes ☐ No

Does the pain travel into your: ☐ Arm/Shoulder ☐ Leg ☐ Does Not Travel ☐ Is this condition getting worse? ☐ Yes ☐ No ☐ Same

Does this interfere with: ☐ Work ☐ Sleep ☐ Hobbies ☐ Family Activities ☐ Daily Routine ☐ Sports/Exercise

Are there any activities that this condition prevents you from doing that you would like to get back to? (eg. playing with kids/grandkids)

If you don't get the problem corrected, do you think it will get worse over the next 5 years? ☐ Yes ☐ No

If we find the cause of the problem & can fix it, on a scale of 1-10, how committed are you to achieving optimal health?
(Please check one of the following boxes):

Not Committed **Moderately Committed** **100% Committed**

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Past History

Have you suffered with this or a similar problem in the past? Yes No If yes, how many occurrences?

When was the last episode? How did the injury happen?

Were other forms of treatment tried: ☐ Yes ☐ No If yes, please state what type of treatment:

When? Results:

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

Have you ever had spinal x-rays taken? ☐ Yes ☐ No If yes, what year were they taken? Where?

Accident/Injury History

Car Accidents (please list all)

Year: Injury: Treatment:

Year: Injury: Treatment:

Sports Injuries (please list all)

Year: Injury: Treatment:

Year: Injury: Treatment:

Slips/Falls: (please list all)

Year: Injury: Treatment:

Year: Injury: Treatment:

Please list any major **surgeries &/or illnesses** you've had and their approximate dates:

Identify any **other injuries to your spine**, minor or major, that the doctor should know about:

Social History

Smoking: ☐ Cigars ☐ Pipe ☐ Cigarettes ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Alcoholic Beverages: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Recreational Drug Use: ☐ Daily ☐ Weekends ☐ Occasionally ☐ Never

Family History

Does anyone in your family suffer with the same condition(s)? Yes No

If yes, whom? ☐ Father ☐ Mother ☐ Sister ☐ Brother ☐ Grandmother ☐ Grandfather ☐ Son(s) ☐ Daughter(s)

Have they ever been treated for their condition? ☐ Yes ☐ No ☐ I don't know

Are there any other **hereditary conditions** the doctor should be aware of?

General Health History

Current Medicines, Vitamins, Supplements:

- ☐ Painkillers
- ☐ Anti-inflammatory
- ☐ Muscle relaxants
- ☐ Blood pressure
- ☐ Stimulants, Anti-depressants
- ☐ Tranquilizers, anti-anxiety
- ☐ Blood Thinners
- ☐ Birth control pills
- ☐ Insulin
- ☐ Vitamins/Supplements
- ☐ Other

Please **check [✔]** the box for symptoms you are **currently experiencing**:

Cranial & Cervical Nerves

- ☐ Neck Pain
- ☐ Pain into your shoulders/arms/hands
- ☐ Numbness/tingling in arms/hands
- ☐ Coldness in hands
- ☐ Weakness in grip
- ☐ TMJ pain/clicking
- ☐ Headaches
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Hearing disturbances
- ☐ Visual disturbances
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Low energy/fatigue
- ☐ Loss of sleep
- ☐ Anxiety/Depression
- ☐ Thyroid conditions
- ☐ Sinusitis
- ☐ Allergies/hay fever
- ☐ Frequent colds/flu

Upper Thoracic Nerves

- ☐ Upper back pain
- ☐ Heart palpitations
- ☐ Heart murmurs
- ☐ Tachycardia
- ☐ Heart attacks/angina
- ☐ Recurrent lung infections/bronchitis
- ☐ Asthma/wheezing
- ☐ Shortness of breath
- ☐ Pain on deep inspiration/expiration

Women Only

- ☐ Menstrual cramps
- ☐ Excessive menstruation
- ☐ Irregular cycle
- ☐ Hot flashes

Are you pregnant?

☐ **Yes** ☐ **No**

Lower Thoracic Nerves

- ☐ Mid back pain
- ☐ Pain into your ribs/chest
- ☐ Indigestion/heartburn
- ☐ Reflux
- ☐ Nausea
- ☐ Ulcers/gastritis
- ☐ Tired/irritable after eating or when you haven't eaten for a while
- ☐ Abdominal bloating
- ☐ Ulcerative intestinal conditions
- ☐ Skin disturbances
- ☐ Hypoglycemia

General Conditions

- ☐ Stroke
- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes

Lumbar & Sacral Nerves

- ☐ Low back pain
- ☐ Pain into your hips/legs/feet
- ☐ Numbness/tingling in your legs/feet
- ☐ Coldness in legs/feet
- ☐ Muscle cramps in your legs/feet
- ☐ Weakness/injuries in your hips/knees/ankles
- ☐ Constipation/diarrhea
- ☐ Recurrent bladder infections
- ☐ Frequent/difficulty urinating
- ☐ Sexual dysfunction

Is there anything else which may help us to better understand you, which has not been discussed? ☐ Yes ☐ No

Please Explain: _____

Signature: _____ Date: _____

Office Use Only