

Date: _____

File #: _____



Alberta Health Care # _____

PATIENT HISTORY

Name: _____ Day _____ Month _____ Year _____ Age _____

Address: _____ Birth Date: ____/____/____ ()

City/Town: _____ Sex: M F

Postal Code: _____ Marital Status: S M D W

Phone: (home): _____ Spouse's Name: _____

(work): _____ Number Of Children: _____

(cell): _____ E-Mail: _____

If Necessary May We Contact You Or Leave A Message? Where? Home Work Cell

Yes No

Describe Major Accidents you have had (e.g. motor vehicle, bad falls):

Accident: _____ Date: _____

Accident: _____ Date: _____

Accident: _____ Date: _____

Are you here because of a car accident? Y N (personal injury claim)

Previous Chiropractor: _____ → Number of visits since last June: _____

Medical Doctor: _____ → Date of Last Examination: _____

Who referred you to our office? _____ → Referring Health Providers will be advised of our findings.

Dentist: _____ Massage Therapist: _____

Physiotherapist: _____ Personal Trainer: _____

Other Health Provider (e.g. Naturopath): _____

Employer: _____ Job Description: _____

Is this a work related injury involving a present or future W.C.B. claim? Y N

Note: Patients are advised that this office has not applied to W.C.B. for preferred provider status and therefore **cannot** treat W.C.B. claimants for job related injury(s).

FILE # _____

List all surgeries and dates:

Surgery: _____ Date: _____ / _____ / _____
Month Day Year
Surgery: _____ Date: _____ / _____ / _____
Surgery: _____ Date: _____ / _____ / _____

Do you have a Diagnosed Disease(s) or Condition(s)? (e.g. Cancer, Diabetes, Epilepsy, Mental/Emotional Condition):

What Childhood Diseases(s) did you have? (e.g. Mumps, Chicken Pox, Measles, etc.):

Do any of your immediate family (e.g. brother, mother, etc.) have a Major Health Problem(s)?

Family Member: _____ Health Problem: _____
Family Member: _____ Health Problem: _____
Family Member: _____ Health Problem: _____

Please check which of the following you have had or are currently experiencing:

Past	Current	Past	Current	Past	Current	Past	Current				
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Cold feet	<input type="checkbox"/>	<input type="checkbox"/>	Throat pain	<input type="checkbox"/>	<input type="checkbox"/>	Poor bladder control
<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Sinus pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	Discolored urine
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ear discharge	<input type="checkbox"/>	<input type="checkbox"/>	Bloody urine
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ear noises	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	<input type="checkbox"/>	Rapid weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	Rash
<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	Bruising	<input type="checkbox"/>	<input type="checkbox"/>	Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	Boils on skin
<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dental decay
<input type="checkbox"/>	<input type="checkbox"/>	Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Asthma symptoms	<input type="checkbox"/>	<input type="checkbox"/>	Curved spine	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>	Spitting phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Leg pain	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Spitting blood	<input type="checkbox"/>	<input type="checkbox"/>	Foot pain	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain / stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis

Do you wear orthotics Y N

Do you have/wear a splint Y N

Check medications you are taking:

Nerve pills Anti-inflammatory Tranquilizers Other: _____
 Birth control Muscle relaxants Vitamins/minerals
 Pain killers Antidepressants Pep pills

For women only: Please check off the following that you experience:

Congested breasts Breast lumps Menstrual pain Excessive flow
 Irregular cycle Hot flashes Vaginal discharge

SPECIFICS OF UPPER CERVICAL CARE

- **Providence Chiropractic Clinic is an upper cervical chiropractic clinic.** This means that our care primarily follows the guidelines and protocols set out by the National Upper Cervical Chiropractic Association (NUCCA). We focus on the correction of occipito-atlanto-axial vertebral misalignment which addresses postural asymmetries.
- **The primary diagnosis that is provided as reason for care within Providence Chiropractic Clinic is that of the Atlas Subluxation Complex Syndrome (ASCS).** The presence of an ASC comes from information contained in the history and our examination findings. Key indicators evaluated include postural distortions, leg length inequality, and range of motion abnormalities. If your history and exam indicate you have an ASC, upper cervical x-rays will be taken to quantify the misalignment factors. You will be advised of any other concerns that may be revealed in your examination. If required, a referral to an appropriate health professional will be made.
- **To treat an ASC, your care follows a 4-week program designed to correct it and maintain the correction.** This program consists of:
 - Day 1 - first adjustment followed by outcome assessment films to evaluate the quality of the correction attained and determine changes in the treatment that might be required to improve your treatment on subsequent visits.
 - Day 3, 7, 14 & 21 - 2 check-ups booked within the first week following the first adjustment and one per week for 2 more weeks to ensure the correction is stabilizing. Repeat treatments will occur ONLY if indications show that the alignment has been lost. Typically only leg length checks are required during these visits to determine the need for an adjustment or not.
 - Day 28 – this re-evaluation appointment is booked 4 weeks after the initial adjustment to repeat the required physical exam measurements. At this time the majority of patients are released into elective care (meaning you come in when you feel the need). If further checkups are indicated, the doctor will discuss that with you at this time.
 - All fees for services provided are non- refundable.