



Updegrove Chiropractic Clinic

General Information

Name _____ Date _____

Address _____

City, Province _____ Postal Code _____

Home Telephone _____ Business Telephone _____ E-Mail _____

Date of Birth (D/M/Y) _____ Age _____ Marital Status - S M D W Sep.

Spouse's Name _____ Children _____

Your Occupation _____

Employer _____

Address _____

City _____ Telephone _____

Emergency Contact _____ Telephone _____

Provincial Health Card Number _____

Were you referred to us? By Whom? _____

Your Health Profile

Your Childhood Years

	Yes	No	?	Details & Comments
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any serious falls as a child? (i.e. crib, bunk bed, trees, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you ever knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any other traumas (physical or emotional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
As a child, were you under regular chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Your Adult Years

	Yes	No	?	Details & Comments
Do or did you ever smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How long? _____
Do you consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many drinks per week? _____
Do you exercise? How much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you consume caffeine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How many cups/bottles per day? _____
How many glasses of water per day?				_____
How many hours of sleep per night?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you wake feeling rested?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you feel overly fatigued during the course of a typical day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rate your appetite				<input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Excellent _____
Do you eat regularly?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner _____
Any significant falls?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Describe _____
Have you ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	For how long? _____
Any surgery or operations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Describe _____
Do you take vitamins, minerals, or other supplements?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Detail _____
Are you currently on any medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Detail _____
Have you ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any family conditions or historical problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Signature _____ Date _____

Condition Details & History

Reason for consulting our office: _____

What are your expectations?: _____

How do you want us to address your problem/condition?

Temporary Relief

Maximum correction

How long have you had this condition? _____

Have you had similar problems in the past? _____

What activities aggravate your condition? _____

Does anything relieve your condition? _____

Is it worse in the morning or the night? _____

Is it constant? _____

How long does it generally last? _____

Does the pain radiate? _____ To what parts of the body? _____

Other Doctors seen for this condition: MD DC DO DDS

Doctor's Name: _____ Diagnosis _____

Doctor's Name: _____ Diagnosis _____

X-Rays taken? ___Y___N___ Treatments? _____

Medications? _____ Physical Therapy? _____

Results: _____

Length of time under care: _____

Is the condition interfering with any of the following?:

Work _____ Sleep _____ Daily Routine _____

Is it getting progressively worse? _____

How long since you've felt good? _____

Patient Past History Form

Name: _____ Date: _____

Please check the appropriate box for any of the following symptoms you have had *within the last year*.

C = Constant F = Frequent (weekly) O = Occasional (monthly/yearly)

C F O Neurological

- Allergy
- Chills
- Convulsions
- Dizziness
- Fainting
- Fevers
- Headaches
- Loss of sleep
- Nervousness
- Depression
- Neuralgia
- Numbness
- Sweats
- Loss of weight
- Tremors

C F O Muscle & Joint

- Arthritis
- Bursitis
- Foot trouble
- Hernia
- Low back pain
- Neck pain
- Neck stiffness
- Pain between shoulders

C F O Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Spitting blood
- Throat phlegm
- Wheezing

C F O Eyes, Ears, Nose & Throat

- Colds
- Crossed eyes
- Deafness
- Dental decay
- Asthma
- Ear aches
- Ear noises
- Sinus infections
- Enlarged glands
- Enlarged thyroid

C F O

- Sore throat
- Tonsillitis
- Eye pain
- Failing vision
- Far sighted
- Gum trouble
- Hay fever
- Hoarseness
- Nasal obstruction
- Near sighted
- Nosebleeds

C F O Cardio-Vascular

- Rapid heart beat
- Slow heart beat
- Swelling of ankle
- Hardening of arteries
- High blood pressure
- Low blood pressure
- Pain over heart
- Poor circulation

C F O Gastro Intestinal

- Excessive hunger
- Burping or gas
- Liver trouble
- Colitis
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Distention of abdomen
- Stomach pain
- Gall bladder trouble
- Hemorrhoids
- Intestinal worms
- Jaundice
- Poor appetite
- Nausea
- Vomiting
- Vomit blood

C F O Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergy
- Itching
- Skin rash
- Varicose veins

C F O Genito-Urinary

- Bed wetting
- Blood in urine
- Frequent urination
- Loss control urine
- Kidney infection
- Painful urination
- Prostate trouble
- Pus in urine
- Smell of urine

C F O Pain or Numbness in :

- Shoulders
- Arms
- Hands
- Hips
- Legs
- Knees
- Ankles
- Feet
- Painful tail bone
- Sciatica
- Swollen joints

C F O For Women Only

- Cramps
- Heavy flow
- Light flow
- Irregular cycle
- Painful cycle
- Discharge
- Sore breasts

Menopausal: Yes No

Last menstruation date: _____

Pregnant: Yes No

Due Date: _____

The Stress Test

Patient: _____ Date: _____

The following three areas of stress can cause a misaligned vertebra (subluxation). Do you recognize any of these stresses? Please circle when you experienced these stresses:

C (child) T (teenager) A (adult) N (never)

Physical Stress

Explain

Birth traumas	C	T	A	N	
Slips/Falls	C	T	A	N	
Car Accidents	C	T	A	N	
Sports injuries	C	T	A	N	
Physical abuse	C	T	A	N	
Work injuries	C	T	A	N	
Poor posture	C	T	A	N	
Sitting on a wallet for years	C	T	A	N	
Sleeping position - stomach	C	T	A	N	
Extensive computer work	C	T	A	N	
Carrying heavy purse/book bag/child	C	T	A	N	
Repetitive lifting/bending	C	T	A	N	
Driving for many hours	C	T	A	N	
Continuous hours sitting/standing	C	T	A	N	
Shoveling, painting, gardening, cleaning	C	T	A	N	

Emotional Stress

Explain

Relationships	C	T	A	N	
Career	C	T	A	N	
Children	C	T	A	N	
Fast-paced life	C	T	A	N	
Hold in feelings	C	T	A	N	
Quick tempered	C	T	A	N	
Verbal abuse	C	T	A	N	
Perfectionist	C	T	A	N	
Procrastinator	C	T	A	N	
Loss of a loved one	C	T	A	N	

Chemical Stress

List

Smoker? - Amount?	C	T	A	N	
Second hand smoke	C	T	A	N	
Poor diet	C	T	A	N	
Caffeine - amount?	C	T	A	N	
Excessive sugar	C	T	A	N	
Artificial sweeteners	C	T	A	N	
Prescription drugs	C	T	A	N	
Over the counter drugs (Tylenol, Motrin, etc.)	C	T	A	N	

Which do you feel are your primary stresses? _____