DR. BARBARA JAMES, CHIROPRACTIC SERVICES INC.

PLEASE PRINT CLEARLY

**LAST NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ INITIAL\_\_\_\_\_\_\_\_**

**ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POSTAL CODE\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TELEPHONE: HOME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF BIRTH: DAY\_\_\_\_\_\_\_\_ MONTH \_\_\_\_\_\_\_\_\_\_ YEAR\_\_\_\_\_\_\_\_\_ AGE\_\_\_\_\_\_\_ SEX: M\_\_\_\_\_\_ F \_\_\_\_\_\_**

**OCCUPATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NUMBER OF CHILDREN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REFERRED BY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CARE CARD NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ICBC CLAIM #\_\_\_\_\_\_\_\_\_\_\_\_ E-MAIL CONTACT \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MAJOR PROBLEM:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW LONG HAVE YOU HAD IT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHAT CAUSED IT?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### WHAT MAKES IT BETTER?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### WHAT MAKES IT WORSE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### TREATMENT RECEIVED?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### OTHER HEALTH CONDITIONS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEAD INJURIES: (DESCRIBE INCIDENT AND DATE)

(e.g. TODDLER LEARNING TO WALK, ACCIDENTS, SPORTS INURIES, CAR ACCIDENTS, PHYSICAL ABUSE)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**LIST ANY FALLS: (HORSE, SNOWMOBLIE, SLIP ON ICE, ETC. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DENTAL HISTORY:** (METAL FILLINGS, ROOT CANALS, JAW PROBLEMS, BRACES)**:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE MARK AREAS OF PAIN ON FIGURES BELOW (Circle areas and mark with an X)**



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PLEASE INDICATE THOSE CONDITIONS THAT APPLY TO YOU

|  |  |  |  |
| --- | --- | --- | --- |
| **GENERAL**ALLERGYCHILLSCONVULSIONDEPRESSIONDIZZINESSFAINTINGFATIGUEFEVER HEADACHES IMMUNE SYSTEM LOWIRRITABILITYLOSS OF SLEEPNERVOUSNESSNEURALAGIANUMBNESSSWEATSTREMORS WEIGHT LOSS **MUSCLES AND JOINTS** ARTHRITISBURSITISFOOT TROUBLEHERNIA LOW BACK PAINNECK PAIN OR STIFFPAIN BETWEEN SHOULDERS ARMS ELBOWSHANDS HIPSLEGSKNEES FEETPAINFUL TAILBONEPOOR POSTURESCAR TISSUESCIATICASPINAL CURVATURESWOLLEN JOINTS TENDINITIS | **GASTR0-INTESTINAL**ABDOMEN DISTENTIONARTERIOSCLEROSISBELCHING OR GASCOLITISCOLON TROUBLEDIARRHEADIFFICULT DIGESTIONCONSTIPATIONEXCESSIVE HUNGERGALL BLADDER PAINHEMORROIDSHERNIAJAUNDICELIVER TROUBLENAUSEAPAIN OVER STOMACHVOMITINGVOMITING OF BLOOD**EYES, EARS, NOSE****AND THROAT**ASTHMACOLDSCONGESTIONDEAFNESSDENTAL CAREEARACHEEAR DISCHARGEEAR NOISESENLARGED GLANDSENLARGED THYROIDEYE PAINFAILING VISIONFARSIGHTNESSGUM TROUBLE HAYFEVERHOARSENESSNASAL OBSTRUCTIONNEARSIGHTNESS NOSE BLEEDSRINGING IN THE EARSINUS INFECTIONSORE THROATTONSILLITIS | **CARDIOVASCULAR**ARTERIOSCLEROSISHARDENING ARTERIESHEART DISEASEHIGH BLOOD PRESSURELOW BLOOD PRESSUREPAIN OVER HEARTPOOR CIRCULATIONRAPID HEART BEATSLOW HEART BEATSTROKESWELLING ANKLES**RESPIRATORY**CHEST PAINCHRONIC COUGHCOPDDIFFICULT BREATHINGEMPHYSEMASPITTING BLOODSPITTING UP PHLEGMTUBERCULOSIS **SKIN**BOILSBRUISE EASILYDRYNESSHIVES OR ALLERGYITCHINGSKIN ERUPTIONSVARICOSE VEINS**GENITO-URINARY**BED WETTINGBLOOD IN URINEFREQUENT URINATIONINABILITY TO CONTROLBLADDER INFECTIONSKIDNEY INFECTIONKIDNEY STONESPAINFUL URINATIONPROSTATE TROUBLE | **FOR WOMEN ONLY**CONGESTED BREASTSCRAMPS OR BACKACHEEXCESSIVE MENSESHOT FLASHESIRREGULAR CYCLELUMPS IN BREASTSMENOPAUSE SYMPTOMSVAGINAL DISCHARGEYEAST INFECTIONSOTHER**OTHER**ADDICTIONANEMIAAPPENDICITISCANCERCOLD SORESDIABETESDIPTHERIAECZEMAEMF SENSITIVEEPILEPSYFOOD SENSITIVITIESGOITER GOUTINFLUENZAMALARIAMEASLESMISCARRIAGEMULTIPLE SCLEROSISMUMPSPLEURISYPOLIORHEUMATIC FEVERSCARLET FEVERSTDTHYROID LOW/HIGHULCERSWHOOPING COUGH |

**WHAT THINGS DO YOU DO ON A REGULAR BASIS FOR YOUR HEALTH?**

**REGULAR EXERCISE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STRETCHES\_\_\_\_\_\_\_\_\_\_HOW OFTEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**VITAMINS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CLEANSING\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SLEEPING POSITION: STOMACH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SIDE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BACK\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SITTING POSITION: SLOUCHED\_\_\_\_\_\_ LEGS CROSSED\_\_\_\_\_\_ ERECT \_\_\_\_\_\_LUMBAR SUPPORT CUSHION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**USING FOOT SUPPORTS/ORTHOTICS?\_\_\_\_\_\_\_\_\_SPORTS SHOES ONLY\_\_\_\_\_\_ALL SHOES\_\_\_\_\_\_\_**

**DIET: Blood Type \_\_\_\_\_\_\_**

**HOW MUCH DO YOU EAT OR DRINK OF THE FOLLOWING FOODS, PER DAY?**

**FRUIT\_\_\_\_\_\_\_VEGETABLES \_\_\_\_\_CARBOHYDRATES\_\_\_\_\_\_\_\_ MEAT\_\_\_\_\_\_\_\_\_VEGETARIAN?\_\_\_\_\_\_\_\_\_FAT\_\_\_\_\_\_ FIBRE\_\_\_\_\_\_\_\_\_**

**DAIRY\_\_\_\_\_\_\_\_\_\_\_\_\_WHITE FLOUR\_\_\_\_\_\_\_\_\_SALT\_\_\_\_\_\_\_\_\_GLUTEN-FREE?\_\_\_\_\_\_\_\_\_\_LACTOSE INTOLERANT? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**COFFEE \_\_\_\_\_\_\_\_\_\_\_\_TEA (REGULAR) \_\_\_\_\_\_\_\_\_\_\_\_\_\_TEA (HERBAL)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_POP/DIET POP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOOD SENSITIVITIES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

ALCOHOL (DRINKS PER DAY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CIGARETTES (PACKS PER DAY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WATER (TYPE AND AMOUNT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**STRESS:**

**ARE THERE ANY STRESSFUL EVENTS OCCURRING IN YOUR LIFE NOW?** (EG: DIVORCE, SICKNESS IN FAMILY)

**BRIEF DESCRIPTION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ARE THERE ANY RECURRING STRESSFUL SITUATIONS? (**WORK, SPOUSE, FINANCES) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WHAT DO YOU WORRY ABOUT MOST? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HOW DOES IT AFFECT YOU?** (EATING MORE/ LESS, SLEEPING MORE/LESS, CONFUSION, IRRITABLE) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICAL HISTORY:**

##### LIST SURGICAL PROCEDURES WITH DATES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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##### LIST ALL DRUGS PRESENTLY TAKEN (PRESCRIPTION OR OVER THE COUNTER e.g. BIRTH CONTROL, ANTACIDS, TYLENOL) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HAVE YOU BEEN X-RAYED IN THE PAST 6 MONTHS YES\_\_\_\_\_\_\_NO\_\_\_\_\_\_ WHERE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ARE YOU PREGNANT? \_\_\_\_\_\_\_\_\_\_\_LAST PERIOD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HAVE YOU EVER BEEN TO A CHIROPRACTOR? NO\_\_\_\_\_\_\_YES\_\_\_\_\_\_WAS TREATMENT HELPFUL?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **WHAT WAS IT FOR?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WHO?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WHEN? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHAT TYPE OF CARE IS AVAILABLE?**

**RELIEF CARE:** PEOPLE GO TO CHIROPRACTORS FOR A VARIETY OF REASONS. SOME GO FOR SYMPTOMATIC RELIEF OF PAIN OR DISCOMFORT.

**CORRECTIVE CARE:** OTHERS ARE INTERESTED IN HAVING THE CAUSE OF THE PROBLEM AS WELL AS THE SYMPTOMS CORRECTED AND RELIEVED.

**COMPREHENSIVE CARE:** STILL OTHERS WANT THEIR BODIES BROUGHT TO THE HIGHEST STATE OF HEALTH POSSIBLE WITH CHIROPRACTIC CARE.

**PLEASE CIRCLE THE TYPE OF CARE YOU WISH, OR WOULD YOU LIKE THE DOCTOR TO SELECT THE APPROPRIATE CARE FOR YOUR CONDITION?**

THE PURPOSE OF OUR CHIROPRACTIC OFFICE IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND HEALTH AND CHIROPRACTIC.

PATIENT’S SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GUARDIAN’S SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THANK YOU FOR FILLING THIS FORM OUT**

**Dr. Barbara James**

**1333 St. Paul St.**

**Kelowna, BC**

**250-868-2951**

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