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 _____

MSP NUMBER _____ ICBC CLAIM #_____ E-MAIL CONTACT _____

MAJOR PROBLEM:

_____

_____

_____

HOW LONG HAVE YOU HAD IT_____

TREATMENT RECEIVED_____

WHAT CAUSED IT_____

OTHER HEALTH CONDITIONS _____

_____

HEAD INJURIES: (DESCRIBE INCIDENT AND DATE)_____

BIRTH PROCESS_____

FALLS WHEN LEARNING TO WALK_____

FALLS FROM CHANGE TABLE OR BED_____

HITTING HEAD ON COFFEE TABLE OR FLOOR_____

CHILDHOOD ACCIDENTS_____

SPORTS INJURIES_____

CAR ACCIDENTS_____

INDUSTRIAL ACCIDENTS _____

PHYSICAL ABUSE

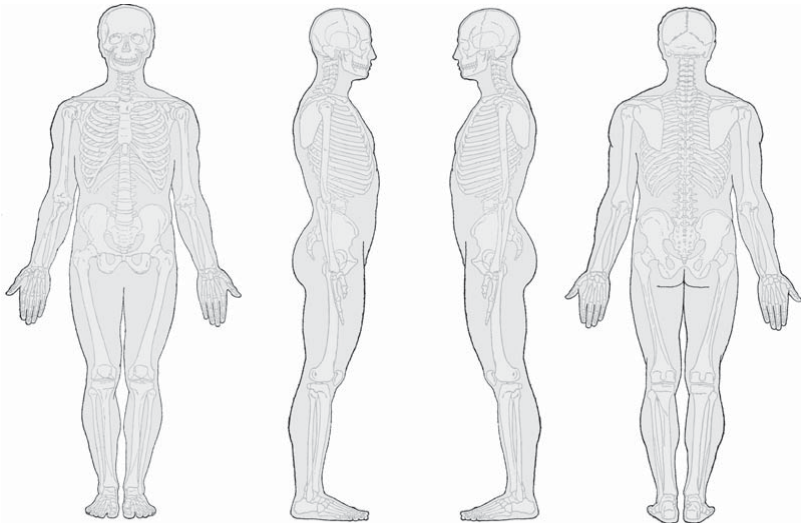
LIST ANY FALLS: (HORSE, SNOWMOBLIE, SLIP ON ICE, ETC. _____

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

_____

_____

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



PLEASE INDICATE THOSE CONDITIONS THAT APPLY TO YOU

GENERAL
ALLERGY
CHILLS
CONVULSIONS
DIZZINESS
FAINTING
FATIGUE
FEVER
HEADACHES
LOSS OF SLEEP
WEIGHT LOSS
NERVOUSINESS
NEURALAGIA
NUMBNESS
SWEATS
TREMORS
MUSCLES AND JOINTS
ARTHRITIS
BURSITIS
FOOT TROUBLE
HERNIA
LOW BACK PAIN
NECK PAIN OR STIFF
PAIN BETWEEN
SHOULDERS
ARMS
ELBOWS
HANDS
HIPS
LEGS
KNEES
FEET
PAINFUL TAILBONE
POOR POSTURE
SCIATICA
SPINAL CURVATURE
SWOLLEN JOINTS
LEARNIND DISABILITY
READING
MATH
MEMORY
SPEECH

GASTRO-INTESTINAL
ABDOMEN DISTENTION
BELCHING OR GAS
COLITIS
COLON TROUBLE
DIARREHEA
DIFFICULT DIGESTION
CONSTIPATION
EXCESSIVE HUNGER
GALL BLADDER PAIN
HEMORROIDS
HERNIA
JAUNDICE
LIVER TROUBLE
NAUSEA
PAIN OVER STOMACH
POOR APPETIE
VOMITING
VOMITING OF BLOOD
EYES, EARS, NOSE AND THROAT
ASTHMA
COLDS
CONGESTION
DEAFNESS
DENTAL CARE
EARACHE
EAR DISCHARGE
EAR NOISES
ENLARGED GLANDS
ENLARGED THYROID
EYE PAIN
FAILING VISION
FARSIGHTNESS
GUM TROUBLE
HAYFEVER
HOARSENESS
NASAL OBSTRUCTION
NEARSIGHTNESS
NOSE BLEEDS
SINUS INFECTION
SORE THROAT
TONSILLITIS

CARDIOVASCULAR
HARDENING ARTERIES
HIGH BLOOD PRESSURE
LOW BLOOD PRESSURE
PAIN OVER HEART
POOR CIRCULATION
RAPID HEART BEAT
SLOW HEART BEAT
SWELLING ANKLES
RESPIRATORY
CHEST PAIN
CHRONIC COUGH
DIFFICULT BREATHING
SPITTING BLOOD
SPITTING UP PHLEGM
WHEEZING
SKIN
BOILS
BRUISE EASILY
DRYNESS
HIVES OR ALLERGY
ITCHING
SKIN ERUPTIONS
VARICOSE VEINS
GENITO-URINARY
BED WETTING
BLOOD IN URINE
FREQUENT URINATION
INABILITY TO CONTROL
KIDNEYS
KIDNEY INFECTIION
KIDNEY STONES
PAINFUL URINATION
PROSTATE TROUBLE
PUS IN URINE
FOR WOMEN ONLY
CONGESTED BREASTS
CRAMPS OR BACKACHE
EXCESSIVE MENSES
HOT FLASHES
IRREGULAR CYCLE
LUMPS IN BREASTS
MENOPAUSE SYMPTOMS
VAGINAL DISCHARGE
YEAST INFECTIONS

OTHER
ALCOHOLISM
ANEMIA
APPENDICITIS
ARTERIOSCLEROSIS
ARTHRITIS
CANCER
CHOREA
COLD SORES
DIABETES
DIPTHERIA
ECZEMA
EMPHYSEMA
EPILEPSY
FEVER BLISTERS
GOITER
GOUT
HEART DISEASE
INFLUENZA
LUMBAGO
MALARIA
MEASLES
MISCARRIAGE
MULTIPLE SCLEROSIS
MUMPS
PLEURISY
POLIO
RHEUMATIC FEVER
SCARLET FEVER
STROKE
TUBERCULOSIS
TYHIOD FEVER
ULCERS
VENEREAL DISEASE
WHOOPING COUGH
STRESS SYMPTOMS
DIZZINESS
BLURRED VISION
RINGING IN EARS
LOW RESISTANCE
NERVOUSNESS
DEPRESSION
IRRITABILITY

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)_____

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 _____
_____
LIST ALL DRUGS PRESENTLY TAKEN (PRESCRIPTION OR OVER THE COUNTER eg. 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 CENTER IS TO SUPPORT EACH INDIVIDUAL IN ACHIEVING THEIR OPTIMUM HEALTH AND TO EDUCATE THEM SO THAT THEY MAY UNDERSTAND HEALTH AND CHIROPRACTIC AND IN TURN EDUCATE OTHERS.

PATIENT'S SIGATURE _____

GAURDIANS SIGNAT URE _____DATE _____

THANK YOU FOR FILLING THIS FORM OUT

Dr. Barbara James
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