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

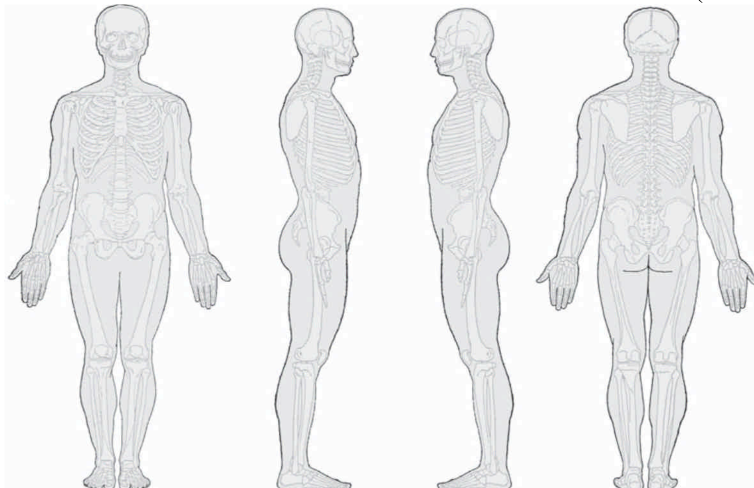
LIST ANY FALLS: (HORSE, SNOWMOBLIE, SLIP ON ICE, ETC. _____________________________________

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

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