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)**:**

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

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**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  CONVULSION  DEPRESSION  DIZZINESS  FAINTING  FATIGUE  FEVER  HEADACHES  IMMUNE SYSTEM LOW  IRRITABILITY  LOSS OF SLEEP  NERVOUSNESS  NEURALAGIA  NUMBNESS  SWEATS  TREMORS  WEIGHT LOSS  **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  SCAR TISSUE  SCIATICA  SPINAL CURVATURE  SWOLLEN JOINTS  TENDINITIS | **GASTR0-INTESTINAL**  ABDOMEN DISTENTION  ARTERIOSCLEROSIS  BELCHING OR GAS  COLITIS  COLON TROUBLE  DIARRHEA  DIFFICULT DIGESTION  CONSTIPATION  EXCESSIVE HUNGER  GALL BLADDER PAIN  HEMORROIDS  HERNIA  JAUNDICE  LIVER TROUBLE  NAUSEA  PAIN OVER STOMACH  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  RINGING IN THE EAR  SINUS INFECTION  SORE THROAT  TONSILLITIS | **CARDIOVASCULAR**  ARTERIOSCLEROSIS  HARDENING ARTERIES  HEART DISEASE  HIGH BLOOD PRESSURE  LOW BLOOD PRESSURE  PAIN OVER HEART  POOR CIRCULATION  RAPID HEART BEAT  SLOW HEART BEAT  STROKE  SWELLING ANKLES  **RESPIRATORY**  CHEST PAIN  CHRONIC COUGH  COPD  DIFFICULT BREATHING  EMPHYSEMA  SPITTING BLOOD  SPITTING UP PHLEGM  TUBERCULOSIS    **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  BLADDER INFECTIONS  KIDNEY INFECTION  KIDNEY STONES  PAINFUL URINATION  PROSTATE TROUBLE | **FOR WOMEN ONLY**  CONGESTED BREASTS  CRAMPS OR BACKACHE  EXCESSIVE MENSES  HOT FLASHES  IRREGULAR CYCLE  LUMPS IN BREASTS  MENOPAUSE SYMPTOMS  VAGINAL DISCHARGE  YEAST INFECTIONS  OTHER  **OTHER**  ADDICTION  ANEMIA  APPENDICITIS  CANCER  COLD SORES  DIABETES  DIPTHERIA  ECZEMA  EMF SENSITIVE  EPILEPSY  FOOD SENSITIVITIES  GOITER  GOUT  INFLUENZA  MALARIA  MEASLES  MISCARRIAGE  MULTIPLE SCLEROSIS  MUMPS  PLEURISY  POLIO  RHEUMATIC FEVER  SCARLET FEVER  STD  THYROID LOW/HIGH  ULCERS  WHOOPING 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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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**

**#1 – 1890 Ambrosi Road**

**Kelowna, BC**

**250-868-2951**