



BARRYDOWNE FAMILY CHIROPRACTIC

Personal Information

Name: _____ Date of Birth: _____ Age: _____ Gender M / F
Address: _____ City: _____ Postal Code: _____
Home Telephone #: _____ Cell #: _____ Work# _____
Email: _____

Is it okay to send you appointment reminders via email? Yes No

Is it okay to contact you at work? Yes No

Marital Status: Single Married Partnered Widowed Divorced

Number of Children: _____

Occupation: _____ Name of Business: _____

Emergency Contact Name: _____

Emergency Contact Number: _____

Medical Doctor: _____ Phone: _____

Last Physical Exam: _____

Have you had previous Chiropractic care? Yes No

Where? _____ When? _____

How did you hear about us? _____

Reason for your visit? Health Optimization Injury Complaint Other

Health Information

What brings you into our office today? _____

Past Health History

Please check if you presently have or have had any of the following conditions in the past:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Blurring of Vision | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Stomach | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Respiratory condition | <input type="checkbox"/> Heart Burn |
| <input type="checkbox"/> Urinary Frequency | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Numbness or Tingling in Arms or Legs | <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Hiatus Hernia | |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Constipation | <input type="checkbox"/> Ringing In Ears |
| <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Unexplained Weight Loss/Gain | | <input type="checkbox"/> Changes to bowel or bladder habits | |
| <input type="checkbox"/> Poor Coordination | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Ear Infections |

Other health problems? _____

Please check off any surgeries you have had and record the year:

- Appendectomy _____ Tonsillectomy _____ Broken Bones _____
- Gallbladder _____ Hernia _____ Spinal Surgery _____
- C-Section _____ Other _____

Have you recently had dental work done? _____

List of medications you now take: _____

Date of last dose of antibiotics? _____

List of supplements you take (including brand if known): _____

List and describe any auto accidents or other accidents/injuries: _____

List and describe any childhood injuries/accidents/hospitalizations/illnesses: _____

Have you been diagnosed with any concussions? Yes No

If yes, list the date of your last concussion _____

Female Only

Are you pregnant? Yes No Not sure If yes, how many weeks? _____

Are you breastfeeding? Yes No

Are you presently trying to conceive? Yes No

Are you taking birth control? Yes No

What was the 1st day of your last period? _____

Do you have irregular or painful periods? Yes No

Have you reached menopause? Yes No

Any pelvic conditions/surgeries (such as PCOS, endometriosis, fibroids, hysterectomy): Yes No

If Yes, please explain _____

Are you on HRT? Yes No

Lifestyle

Rate your diet: Poor Fair Medium Good Excellent

Do you follow a special diet? (gluten free, vegan, Paleo, dairy free, Etc?) _____

Rate your sleep habits: Poor Fair Medium Good Excellent

How often do you exercise: Daily 3-5 Days/Week 1-2 Days/Week Infrequent

Average length of workout >30 minutes 30-60 Minutes <60 minutes

Types of exercise done: Cardio Resistance Intervals Yoga

How well do you cope with stress? Poorly Ok Well

Rate your energy level: Exhausted Low Good Excellent

Do you use tobacco? Yes No

If Yes, Packs/day _____

Year Quit _____

Do you drink coffee? Yes No

If yes, how many cups/day? _____

Do you drink pop? Yes No

If yes, how many cans/day? _____

Anything else you feel we should know about?
