Lethbridge Chiropractic
Dr. Brandon Workman D.C 122 A 5 Street S., Lethbridge, AB T1J 2B2
Phone 403-524-2929 Fax 403-524-2929 www.lethbridgechiropractic.ca

NEW PATIENT REGISTRATION

Name____ Date of Birth_____M_____D_______Y
Last First Middle

Address________________________________ ______ ______________ __________ __________
Street Apt# City Province Postal Code

AB Health Care # ______________________ Gender: M / F Third Party Insurance ___ Yes ___ No

Home Phone #(____)____–_______ Work Phone #(____)____–_______Cell Phone # (____)_____–_______

E-mail Address: ____

Employer___________________________Occupation_________________ Phone# (_____)______–_______

Emergency Contact______________________ Relationship____________ Phone# (_____)______–_______

How did you hear about us? Print Ad ___ Internet ___ Word of Mouth ___ Other?_______________________

Whom may we thank for referring you?_____________________________________

Please check all answers and fill in the blanks where appropriate:

Reason(s) for appointment: ____

____

When & how did your condition begin? ____

Is it? ___Constant ___ Frequent ___ Occasional - Is your condition getting worse? ___ Yes ___ No

Have you ever had similar problems? ___ Yes ___ No If yes – When_______________________________

____

Have you had X-rays, MRI, or other tests for this condition? ___Yes ___No Which tests,
when?_______________________

____

Is this a work related injury? ___ Yes ___ No If yes, has your employer been notified? ___ Yes ___ No

Is this a Motor Vehicle Accident (MVA)? ___ Yes ___ No If yes, on what date did the accident occur?_________________

Can you perform daily home activities? ___ Yes ___ Yes, but only with help ___ Not at all

Can you perform your daily work activities? ___ All activities ___ Only some activities ___ Not at all

Describe your stress level: ___ None ___ Mild ____ Moderate ___ High

Do you exercise? ___Daily ___Occasionally ___Not at all

What kind of exercise do you do? ____

____
_

List all previous surgeries, illnesses, injuries (including MVA): ____

____

____

Have you had previous chiropractic care? ___Yes ___No Dr. __________________ Date:
____

Are you under the care of a physician? ___Yes ___No If yes, Name ___________ For what
reason:__________________

____
_

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List all medications, over the counter and prescriptions, supplements, vitamins, herbal supports, aspirin, etc.:____________
____
____

Indicate the location of your pain by shading in the appropriate area(s)

Does your pain radiate?:
Yes___ No ___
Where: __________________
____
____

Associated symptoms:
____
____
____

What aggravates your condition?
____
____

What relieves it?
____
____
____

Indicate the severity of the pain by circling a number:
(0 1 2 3 4 5 6 7 8 9 10)

Health History Questionnaire

Have you ever been diagnosed or told you have any of the following? Circle the correct response.

1. High blood pressure ____ Yes No
2. Hardening of the arteries (arteriosclerosis) ___________________________ Yes No
3. Diabetes ____ Yes No
4. Tuberculosis ____ Yes No
5. Cancer ____ Yes No
   Where? ____ Yes No
6. Heart or blood diseases ____ Yes No
7. Bone spurs on the neck bones (cervical sprain) _______________________ Yes No
8. Whiplash injury (flexion-extension injury, cervical sprain) ________________ Yes No
9. Have you or any of your relatives ever suffered a stroke? ________________ Yes No
10. Were you ever a smoker? _______________________________________ Yes No
    From __________________ to _______________________
11. Do you take medication on a regular basis? ____________________________ Yes No
12. Visual disturbaqnces (blurring, loss, double vision) ______________________ Yes No
13. Hearing disturbances (loss, ringing, other noise) ________________________ Yes No
14. Slurred speech or other speech problems ______________________________ Yes No
15. Difficulty swallowing ____ Yes No
16. Dizziness ____ Yes No
17. Loss of consciousness, even monmentary blackouts _____________________ Yes No
18. Numbness, loss of sensation, loss of strength or weakness in the face, fingers, hands, arms, legs or any other parts of the body? __________________ Yes No
19. Sudden callapse without loss of consciousness __________________________ Yes No

Family Health History: (Immediate family members and grandparents) Give relationship and past & present health problems:
____
____
____

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______________________________ ______________________________
Patient Signature Date