Dr. Karen Proctor
Chiropractor

Back on Track Chiropractic & Massage Clinic
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CONFIDENTIAL PATIENT CASE HISTORY

PATIENT INFORMATION: **DATE:** _____

First Name: _____ Last Name: _____

Street Address: _____

City: _____ Postal Code: _____ Email: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Birth Date: _____ Age: _____ Sex at birth: **Male / Female / Prefer not to say**

Preferred Pronouns (optional): _____ Marital Status: _____

Occupation: _____ Employer: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Contact Number: _____

PHYSICIAN INFORMATION (if known):

Physician Name: _____ Physician Phone: _____

☐ **Consent to contact Physician and share your medical history.**

REFERRALS:

How did you hear about us? ☐ Friend ☐ Internet ☐ Signage Other: _____

Do you have a family history of:

Cancer	**YES**	**NO**		Heart disease/stroke	**YES**	**NO**	
Diabetes	**YES**	**NO**		Allergies	**YES**	**NO**	

Please indicate areas of concern or discomfort that you wish to discuss with the Doctor:

- ☐ Lower back pain
- ☐ Middle back pain
- ☐ Neck back pain
- ☐ Headaches
  - ☐ Tension
  - ☐ Migraine
  - ☐ Other
- ☐ Facial pain
- ☐ Temporomandibular joint pain
- ☐ Generalized joint pain
- ☐ Generalized muscle pain
- ☐ Chronic fatigue syndrome
- ☐ Shoulder pain/injury
- ☐ Arm pain
- ☐ Elbow pain
- ☐ Wrist pain
- ☐ Hand pain
- ☐ Knee pain
- ☐ Ankle pain
- ☐ Foot pain
- ☐ Leg pain
- ☐ Respiratory pain
- ☐ Abdominal pain
- ☐ Nutrition
- ☐ Wellness protection
- ☐ Chest pain
- ☐ Other: _____

ABOUT THIS OFFICE

This wellness clinic has a philosophy to health that involves a multidiscipline approach to health and health care. It involves the relief of pain and symptoms, full rehabilitation, and education on exercise, nutrition, and stress management. These factors together result in general well-being and lead to a better quality and enjoyment of life. It is your choice to receive these different levels of care.

MEDICAL HISTORY

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES? IF SO, PLEASE INDICATE:

- ☐ Respiratory conditions
- ☐ High blood pressure
- ☐ Sleep difficulty
- ☐ Aneurysm
- ☐ Cancer
- ☐ Heart condition
- ☐ HIV
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Fatigue
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Pneumonia
- ☐ Psoriasis

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES? IF SO, PLEASE INDICATE:

GENERAL SYMPTOMS:

- ☐ Headache
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Numbness or pain in arms, hands, legs
- ☐ Loss of sleep
- ☐ Fatigue
- ☐ Loss of weight
- ☐ Allergy
- ☐ Wheezing
- ☐ Neuralgia

MUSCLE AND JOINT:

- ☐ Stiff neck
- ☐ Back ache
- ☐ Spinal curvature
- ☐ Neck pain

MUSCLE AND JOINT CONT'D:

- ☐ Swollen joints
- ☐ Painful tailbone
- ☐ Foot trouble
- ☐ Pain in shoulders
- ☐ Faulty posture
- ☐ Hernia
- ☐ Arthritis

SKIN:

- ☐ Bruises easily
- ☐ Varicose veins
- ☐ Sensitive skin
- ☐ Hives or allergy

RESPIRATORY:

- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Chest pain

CARDIOVASCULAR:

- ☐ Rapid beating heart
- ☐ Slow beating heart
- ☐ Previous heart stroke
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Pain over heart
- ☐ Hardening of arteries
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Paralytic stroke

GENITOURINARY:

- ☐ Kidney stones
- ☐ Kidney infection
- ☐ Inability to control urine
- ☐ Prostate trouble

GASTROINTESTIONAL:

- ☐ Poor appetite
- ☐ Difficulty digesting

GASTROINTESTIONAL CONT'D:

- ☐ Excessive hunger
- ☐ Colitis
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting
- ☐ Pain over stomach
- ☐ Colon trouble
- ☐ Constipation
- ☐ Vomiting of blood
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Jaundice

E.E.N.T

- ☐ Asthma
- ☐ Enlarged glands

Intake and Consent

What are you needing help with? Please tell us your story (please be concise.):

_____

Expectations (list top 3 expectations)

_____

_____

What is your commitment to treating your symptoms? (10 = extremely committed):

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What level of care are you interested in pursuing?

- ☐ Pain relief
- ☐ Pain relief with rehabilitation through exercise
- ☐ Prevention which involves looking at nutrition, stress management, exercise, postural analysis and good spinal health

How long have you had symptoms/pain? _____

Have you had these symptoms before? ☐ No ☐ Yes (please elaborate) _____

What movements or positions make you feel worse? _____

What can you do to relieve or minimize your symptoms? _____

Are symptoms becoming: ☐Better ☐Worse ☐Comes/Goes ☐Unchanged

Describe your pain:

☐Sharp ☐Dull ☐Burning ☐Throbbing ☐Achy
☐Knife-like ☐Numb ☐Deep ☐Muscular ☐Other

Rate your WORST pain (10 = unbearable):

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Rate your LEAST pain? (0 = no pain):

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Do your symptoms interfere with: ☐ Work ☐ Social Life ☐ Sleep ☐ Fitness Activities

Do you exercise? ☐ Yes ☐ No
If yes, what type of exercise? Frequency? _____

Weekly alcohol consumption (Number of drinks): _____

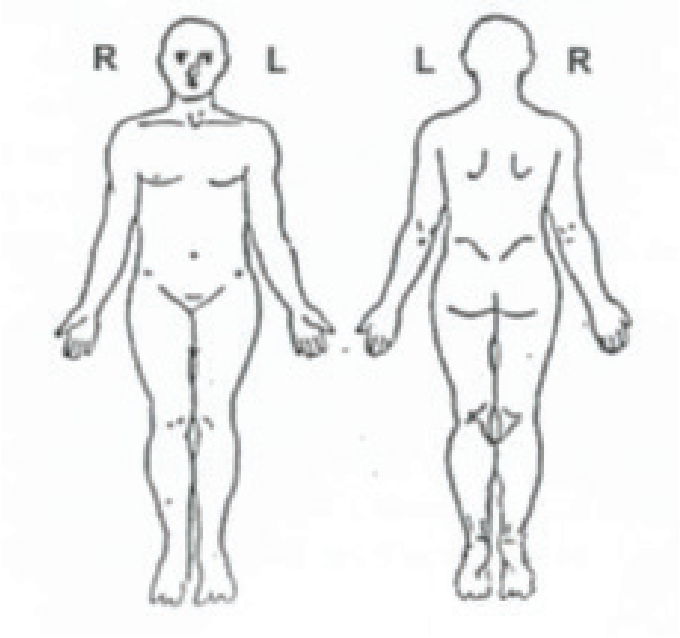
Hours of nightly sleep: _____

What position do you sleep in? ☐ Left side ☐ Right side ☐Stomach ☐Back ☐Toss and turn

VISUAL PAIN RATING SCALE

INSTRUCTIONS: Make a mark (/) along the line which you think represents your current level of pain in your major area of injury, somewhere between "NO PAIN AT ALL" and "PAIN AS BAD AS IT COULD BE"
NO PAIN AT ALL _____ PAIN AS BAD AS IT COULD BE

PAIN DIAGRAM



Indicate on the diagrams any area of:

Stiffness	////////
Numbness	●●●●
Pins and needles	OOOO
Burning	XXXX
Aching	*****
Stabbing	+++++

PATIENT QUESTIONNAIRE (PLEASE CIRCLE)

Any recent diagnostic imaging (CT scan, MRI, Ultrasound)? **YES / NO** Date: _____

Any recent spinal x-rays? **YES / NO** Date: _____

Have you ever been to a chiropractor before? **YES / NO** Dr's name: _____

Results: Excellent Good Fair Poor Date of last visit _____

Do you take any vitamin or mineral supplementation? **YES / NO** List them: _____

Have you ever had a concussion **YES / NO** When: _____

Are you presently under treatment for this problem? **YES / NO** Please indicate below

☐ Physio ☐ RMT ☐ Osteopath ☐ Acupuncture ☐ Other: _____

Are you presently taking any medications? **YES / NO** List them: _____

_____

_____

Are you presently pregnant? **YES / NO** Due date: _____

Accidents or Falls / Fractures or Dislocations (Please describe fully, starting with most recent):

_____

_____

_____

Have you had any surgeries? (If yes please outline):

_____

_____

In signing this form, you agree that this information is correct and consent to a chiropractic examination.

Signature: _____ Date: _____

CANCELLATION POLICY IN EFFECT

We do not double book and we strive to run on time at this office. In order to do this, we only book one patient per appointment. Your appointment is reserved for you.

We realize that schedules and commitments change, should you need to change your appointment we are happy to help you reschedule. Please call us or email us 24 hours ahead of your appointment to avoid cancellation fees. For your convenience, you have the option of opening an online portal that will allow you to cancel or reschedule your appointments 24 hrs ahead of your appointed time. Missed appointments may result in full fee charges.

I have read and understand the cancellation policy

Signature: _____ Date: _____