DR. ROBERT E. ANDERSON, D.C.
ANDERSON CHIROPRACTIC
WELCOME TO OUR OFFICE

Chart# _____

Name _____ Date _____

Address _____

City _____ Province _____Postal Code _____

Home Telephone _____Work _____Cell_____

Email _____ Would you like to be emailed appointment reminders: (Y) (N)

Date of Birth (M/D/Y) _____Provincial Health Card Number _____

Occupation (Your) _____Employer _____

Emergency Contact _____Phone _____

Do you have Extended Health Care Coverage? Y N

If yes, who is your Insurance Company? _____ Would you like us to direct bill? Y N

How did you hear about our office _____

Reason for consulting our office _____
_____

Expectations_____
_____

CLAIM WILL BE MADE AGAINST:

Recent motor vehicle accident (Y) (N) (If Yes, See Accident History Form)

Work related injury/accident (Y) (N)

PRIOR CHIROPRACTIC CARE:

Name _____

X-rays taken (Y) (N) Date _____

Results: Excellent Good Fair Poor

MEDICAL DOCTOR:

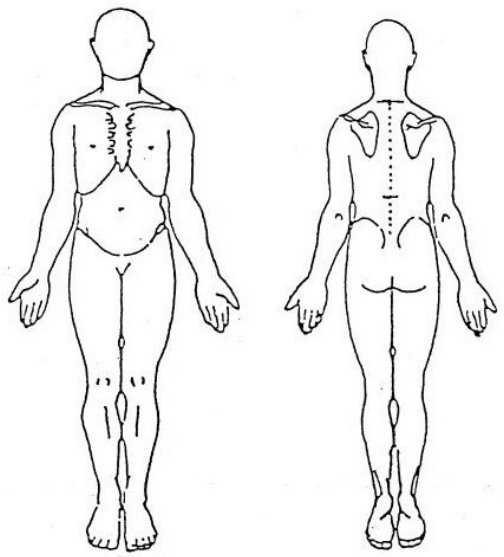
Name _____

Date of Last Appointment _____

Date of Last Physical _____

Draw in your face
Show area(s) of pain or unusual feeling

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.



Numbness ● ● ● ● ●

Pins & Needles Θ Θ Θ Θ Θ

Burning X X X X X

Aching * * * * *

Stabbing / / / / /

Have you ever had any of the following?

□ aneurysm	□ osteoporosis	□ diabetes	□ arthritis	□ allergies
□ respiratory conditions		□ epilepsy	□ cancer	□ strokes
□ heart conditions	□ hepatitis	□ "nerves"	□ fatigue	□ polio
□ sleeping difficulty	□ pneumonia	□ pleurisy	□ asthma	□ V.D.
□ psoriasis	□ HIV	□ sinus conditions		

Please check the following childhood conditions you may have had:

□ measles	□ mumps	□ chicken pox	□ whooping cough
□ scarlet fever	□ diphtheria	□ rheumatic fever	□ typhoid fever
□ ear infections	□ tubes in ears	□ chronic illness	

Please use the following letters to describe any of the following symptoms which you now have or have had previously.

C = Constant F = Frequent O = Occasional

NEUROLOGICAL
___ allergy
___ chills
___ convulsions
___ dizziness
___ fainting
___ fevers
___ headaches
___ loss of sleep
___ nervousness
___ depression
___ neuralgia
___ numbness
___ sweats
___ loss of weight
___ tremors

EYES, EARS NOSE & THROAT
___ colds
___ crossed eyes
___ deafness
___ dental decay
___ asthma
___ ear aches
___ ear discharges
___ ear noises

MUSCLE & JOINT
___ arthritis
___ bursitis
___ foot trouble
___ hernia
___ low back pain
___ neck pain
___ neck stiffness
___ pain between shoulders

PAIN OR NUMBNESS IN:
___ shoulders
___ arms
___ hands
___ hips
___ legs
___ knees
___ ankles
___ feet
___ painful tail bone
___ sciatica
___ swollen joints

CARDIO-VASCULAR
___ rapid heart beat
___ slow heart beat
___ swelling of ankles
___ hardening of arteries
___ high blood pressure
___ pain over heart
___ poor circulation

RESPIRATORY
___ chest pain
___ chronic cough
___ difficulty breathing
___ spitting blood
___ throat phlegm
___ wheezing

GENITO-URINARY
___ bed wetting
___ blood in urine
___ frequent urination
___ loss control urine
___ kidney infection
___ painful urination
___ prostate trouble
___ pus in urine
___ smell of urine

GASTRO INTESTINAL
___ excessive hunger
___ burping or gas
___ liver trouble
___ colitis
___ colon trouble
___ constipation
___ diarrhea
___ difficult digestion
___ distention of abdomen
___ stomach pain
___ gall bladder trouble
___ hemorrhoids
___ intestinal worms
___ jaundice
___ poor appetite
___ nausea
___ vomiting
___ vomit blood

SKIN
___ boils
___ bruise easily
___ dryness
___ hives or allergy
___ itching
___ skin rash
___ varicose veins

FOR WOMAN ONLY
___ cramps
___ heavy flow
___ light flow
___ irregular cycle
___ painful cycle
___ discharge
___ sore breasts

Menopausal (Y) (N)
Last menstruation date:
_____
Pregnant (Y) (N)
Due date: _____

HABITS OF LIFESTYLE:

Do you smoke: (Y) (N) Do you consume alcohol: (Y) (N)

Do you exercise: (Y) (N) Exercise indoor activities: _____
Exercise outdoor activities: _____

How many hours per night do you sleep: 4-6 6-8 8-10 12+

Do you wake rested: (Y) (N)

Rate your appetite: Poor Fair Medium Good Excellent

Rate your diet: Poor Fair Medium Good Excellent

Do you eat regularly: Breakfast Lunch Dinner

Do you eat per day: 1 meal 2 meals 3 meals 4 meals More than 4 meals

Date of last Dental Examination: _____

Falls and Accidents – list: _____
_____

Surgery and Operations – list: _____
_____

Surgery recommended but not performed – list: _____
_____

Do you take vitamins and minerals – list: (Y) (N) _____

List any medications you are currently taking: _____

Have you ever been knocked unconscious: (Y) (N) Don't know

If so, for how long: _____

Have you previously been hospitalized: (Y) (N)

Please list: _____

Any family health conditions or problems: (Y) (N)

Please list: _____

Signature: _____ Date: _____