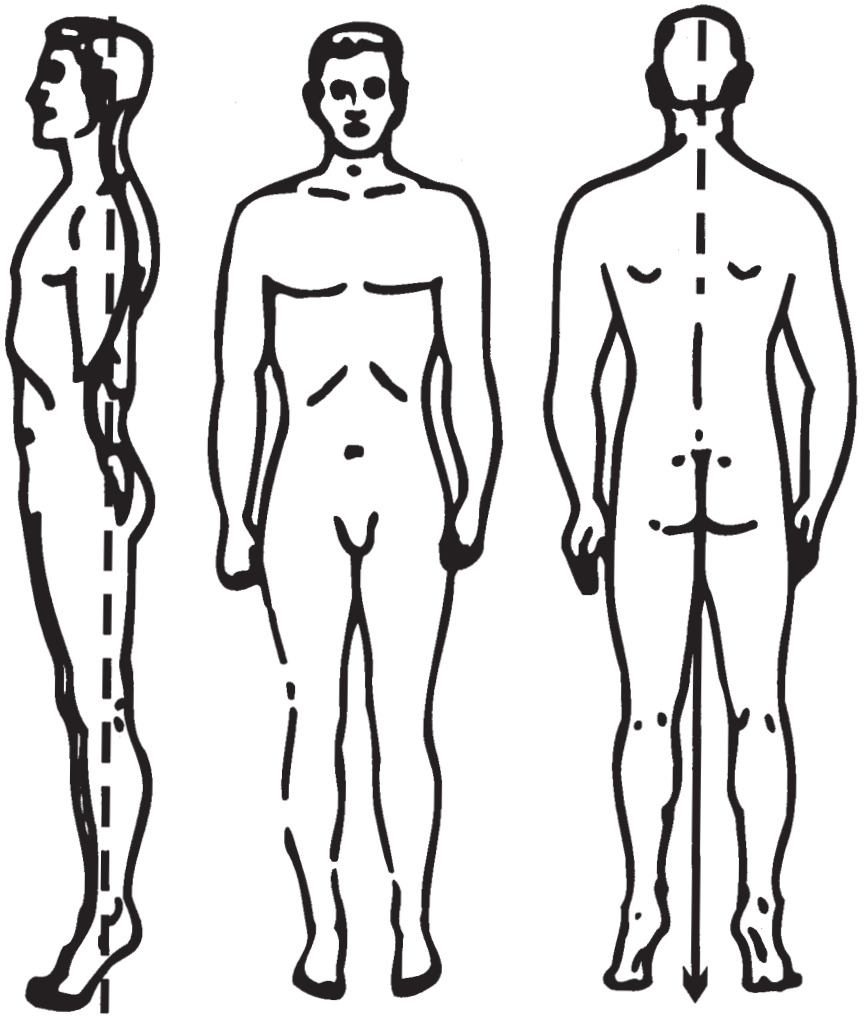
Date of last physical examination:_____

Please mark your areas of pain in the figures below:



Have you ever suffered from any of the following?

(Please check the appropriate box)

- ☐ Dizziness
- ☐ Backaches
- ☐ Heart Trouble
- ☐ Diabetes
- ☐ Arthritis
- ☐ Headaches
- ☐ Asthma
- ☐ Neuritis
- ☐ Digestive Disorders
- ☐ Nervousness
- ☐ Sinus Trouble
- ☐ Neck Pain

Insurance Information

Is your condition due to an auto accident or job related injury? ☐ Yes ☐ No

Family Health Information

Many health problems are the result of hereditary spinal weaknesses; thus information about your family members will give us an understanding of your total health picture.

NAME	RELATION	PAST AND PRESENT HEALTH PROBLEMS

Oak Park Chiropractic - Patient Form

Confidential Patient Case History

Name:_____

Address:_____

City:_____ Province: _____ Postal Code:_____

Home Phone:_____ Cell Phone:_____ Date of Birth:_____ Age: ____
D M Y

Marital Status: M S W D Name of Spouse_____Number of Children_____

Occupation:_____ Work Phone:_____

Work Address:_____

How did you hear about this clinic:_____

HEALTH INFORMATION

Have you been to a Chiropractor before?_____When?_____

Where?_____ Last Visit?_____X-Rays?_____

What is your major complaint?_____

Have you seen someone else regarding this problem?_____

When did this condition begin? _____

Have you had this problem before?_____When?_____

What aggravates your condition?_____Relieves it?_____

Is the problem getting worse?_____Constant?_____Comes & Goes?_____

How long has it been since you felt good?_____

Is this problem interfering with: ☐ Work? ☐ Sleep? ☐ Daily Routine? ☐ Other?_____

Are you on any medication?_____

List any surgical operations:_____

List any broken bones:_____Major Falls:_____

List any car accidents:_____