**Shephard Health**

*Soft Tissue & Sport Therapy*

Suite #200, 1228 Kensington Road N.W.
Calgary, Alberta T2N 3P7
Phone: **(403) 543-7499**
Fax: (403) 543-7497
www.shephardhealth.com

# Patient Information

**Date: _____**
**Last name: _____ First Name: _____ Middle Initial: ____**
**Date of Birth: (m/d/y) _____ Age: _____ Gender: M □ F □**
**Address: _____**
**City: _____ Province: _____ Postal Code: _____**

**Married □ Single □ Kids: _____ Alberta Health Care #: _____**
**Home Phone #: _____Business #:_____ Cell Phone #: _____**
**E-mail Address: _____**
**Emergency Contact:_____Number:_____**

**Would you like automated e-mail appointment reminders 2 days in advance? Yes □ No □**

**How did you hear about us?**

- ☐ **Personal referral** _____
- ☐ **Doctor referral** _____
- ☐ **Physiotherapist** _____
- ☐ **Massage Therapist** _____
- ☐ **Other: (please specify)** _____
- ☐ **Internet**
- ☐ **Phone Book**
- ☐ **Walk-In**

**Family Doctor (Required): _____**
**Business employer: _____ Type of Work: _____**

**Do you have Extended Health Coverage? ☐ Yes ☐ No Insurer: _____**

**ID #:_____ Policy/Group#:_____**

**<u>Motor Vehicle Accident</u> (if applicable)**

**Are you seeking treatment for a Motor Vehicle Accident? Yes □ No □**
**Date of Motor Vehicle Accident: _____**
**Have you seen another practitioner in regards to this accident? Yes □ No □**
**If so, type of practitioner: ☐ Physiotherapist ☐ Chiropractor ☐ Medical Doctor**
**Name of Practitioner: _____ Date of Assessment: _____**

**Car Insurance Company: _____ Phone: _____**
**Name of Adjustor: _____ Fax: _____**
**Claim #: _____ Policy #: _____**

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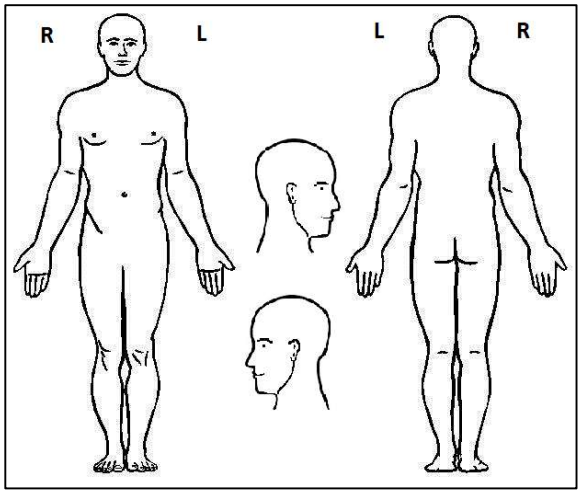
# Current Health Condition

Purpose of this appointment: _____
Major complaint: _____
Explain how complaint happened?: _____
When did this condition begin?:_____
Condition has persisted for: □Days □Weeks □Months □Years
Condition developed from: □Auto Accident □Work Injury □Other Injury_____
Symptoms: □Came on suddenly □Come & Go
What activities make the condition better?:_____
What activities make the condition worse?:_____
Symptoms are BETTER in: □AM □Midday □PM
Symptoms are WORSE in: □AM □Midday □PM □Do not change with time of day
Have you ever had this condition before? □No □Yes, when _____
Other doctors seen for this condition:_____
Describe other complaints involving: Neck/Head: _____
Mid-Back/Shoulders/Arms:_____
Low-Back/Hips/Legs:_____
Medications you are presently taking:_____
For what conditions:_____
On a scale from 1-10 how important is nutrition to you? (1-not important) _____

INDICATE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:
U-unable P-painful D-difficult L-limited N-normal

__Coughing or Sneezing
__Getting in or out of car
__Turning over in bed
__Walking short distances
__Standing more than 1 hour
__Sitting at a table
__Lying on back
__Lying on stomach
__Lying on side w/ knees bent
__Bending over forward
__climbing
__Kneeling
__Balancing
__Dressing self
__Sleeping
__Stooping
__Gripping
__Pushing
__Pulling
__Reaching
__Sex activity

SHADE OR CODE AREAS:
P-pain N-numbness S-spasms T-tenderness




Previous Chiropractic care:_____
All accidents or falls:_____
Surgeries and operations:_____
Hospitilizations:_____
Date of last spinal X-Ray:_____ Where?:_____
Women: Are you pregnant? □Yes □ No Last onset cycle date:_____

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# Past Health History

**Please check any diseases you may have had:**

- □ Rheumatic Fever
- □ Diabetes
- □ Heart Disease
- □ A.I.D.S.
- □ Measles
- □ Small Pox
- □ Cancer
- □ Arthritis
- □ Pneumonia
- □ Mumps
- □ Chicken Pox
- □ Influenza

**Please check any of the following conditions you may have had:**

MUSCULO-SKELETAL
- □ Low Back Pain
- □ Pain Between Shoulders
- □ Neck Pain
- □ Arm Pain
- □ Joint Pain/Stiffness
- □ Walking Problems
- □ Difficulty Chewing/Clicking Jaw
- □ General Stiffness

CARDIO-VASCULAR
- □ Blood Pressure Problems
- □ Heart Problems
- □ Lung Problems/Congestion
- □ Stroke
- □ Chest Pains

MALE/FEMALE
- □ Menstrual Irregularity
- □ Menstrual Cramping
- □ Vaginal Pains/Infection
- □ Breast Pain/Lumps
- □ Prostrate/Sexual Dysfunction

NERVOUS SYSTEM
- □ Nervous
- □ Numbness
- □ Dizziness
- □ Forgetfulness
- □ Confusion/Depression
- □ Fainting
- □ Convulsions
- □ Cold/Tingling Extremities
- □ Stress

DIGESTIVE TRACT
- □ Nausea
- □ Heartburn
- □ Gas/Bloating after Meals
- □ Constipation
- □ Diarrhea
- □ Bowel Infections
- □ Weight Trouble

EYE/EAR/NOSE/THROAT
- □ Vision Problems
- □ Sore Throat
- □ Stuffed Nose and Sinuses
- □ Hearing Difficulty
- □ Ear Aches

GENERAL
- □ Fatigue
- □ Allergies
- □ Loss of Sleep
- □ Headaches
- □ Fever

GENITO-URINARY
- □ Bladder Trouble
- □ Painful Urination
- □ Excessive Urination

EXERCISE (check one)

□ None □ Moderate □ Daily

What?

_____

_____

_____

FAMILY HISTORY (for example, Cancer/Diabetes/Heart Problems/Back or Neck Problems)

Father: _____

Mother: _____

Sibling: _____

HABITS

- □ Smoking: pks/day: _____
- □ Drinking: alcohol/wk:_____
- □ Coffee: cup/day: _____

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (**relief care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**corrective care**). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (**preventative care**). These are the three types of care. As your doctor will weigh your needs and desires when recommending your schedule of care, please check the type of care desired so that we may be guided by your wishes whenever possible.

□ Relief Care □ Corrective Care □ Preventative Care □ Check here is you want the doctor to select the type of care appropriate for your conditions.

I confirm that the information I have provided in regards to my current condition and past health history are true to the best of my knowledge.

**Signature: _____ Date: _____**