

**Dr. Erin A. White, Chiropractor/Kinesiologist
1389 Colborne Rd., Sarnia, Ontario N7V 3L8
(519)332-4222 www.drwhite.ca**

PLEASE COMPLETE THE QUESTIONNAIRE...PLEASE PRINT LEGIBLY

Name Home Tel

Address Business Tel

City Postal Code

E-mail Address

Date of Birth Age
(Day) (Month) (Year)

Married (.....) Single (.....) Divorced (.....) Widowed (.....)

No. of Children

Whom may we thank for referring you?

Employer Occupation

Address City

Extended Health Care Company Policy #

Is this a Compensation Case? ... Motor Vehicle Accident? ... Veteran's Affairs? ...

Does anyone in your family suffer from arthritis, backaches, or headaches?

Name of Emergency Contact Tel

Medical Doctor Name Tel

Address City

Date of Last Appointment

**PAYMENT IS EXPECTED AT THE TIME OF VISIT UNLESS OTHER
ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.**

**PLEASE PHONE 24 HOURS IN ADVANCE IF YOU ARE UNABLE TO KEEP
YOUR APPOINTMENT. THANK YOU.**

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CASE HISTORY

MEDICAL DOCTOR:

PREVIOUS
CHIROPRACTOR:

COMPLAINT

DURATION/FREQUENCY

ONSET

PROGRESSION

PAIN (CHARACTER)

LOCATION

ASSOCIATED S+S

RELIEVING FACTORS

AGGRAVATING FACTORS

PAST HISTORY

TREATMENT

SYSTEMS REVIEW

PAST ILLNESS

FAMILY HISTORY

LIFESTYLE

SECONDARY COMPLAINTS

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TO OUR PATIENTS: Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

PATIENT NAME _____ FILE #: _____ DATE: _____

* PLEASE **CIRCLE** ANY CONDITIONS OR SYMPTOMS PRESENTLY CAUSING YOU PROBLEMS.

* PLEASE CHECK (✓) THOSE CONDITIONS OR SYMPTOMS WHICH HAVE BEEN A PROBLEM TO YOU IN THE PAST.

GENERAL SYMPTOMS

Loss of consciousness
Blackouts
Headache
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions
Loss of sleep
Numbness, pain
or tingling
Nervousness
Loss of weight

MUSCLES & JOINTS

Stiff neck
Back ache
Swollen joints
Painful tail bone
Foot trouble
Shoulder pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Arthritis
Weakness or loss
of strength

E.E.N.T.

Blurred vision
Failing vision (one/both eyes)
Crossed eyes
Double vision
Eye Pain
Deafness
Earache
Ringing, buzzing or any
noise in the ears
Asthma
Frequent colds
Sinus infection
Enlarged glands
Enlarged Thyroid
Slurred or other speech problems
Difficulty swallowing

RESPIRATORY

Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficult breathing

CARDIOVASCULAR

Bleeding disorder
High blood pressure
Pain over the heart
Stroke
Hardening of arteries
Varicose veins
Swelling of ankles
Poor circulation
Heart or blood disease
Angina

GENITOURINARY

Trouble urinating
Blood in urine
Kidney infection
Bed wetting
Prostate trouble

G.U. FOR WOMAN

Painful menstruation
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Vaginal discharge
Swollen breasts
Lumps in breasts

HAVE YOU EVER BEEN ON THE BIRTH CONTROL PILL?

Yes No

ARE YOU CURRENTLY TAKING THE BIRTH CONTROL PILL?

Yes No

Pregnancies _____

Children _____

Abortions _____

SKIN

Rashes, itching, dryness
Bruise easily
Boils
Hives (allergy)

GASTROINTESTINAL

Poor appetite
Indigestion
Excessive hunger
Belching or gas
Nausea
Vomiting (blood?)
Pain over stomach
Constipation
Diarrhea
Hemorrhoids (piles)
Jaundice
Gall bladder trouble
Intestinal worms
Ulcer
Diabetes

HAVE YOU EVER HAD ANY FRACTURES? Yes No

HAVE YOU EVER BEEN IN A CAR ACCIDENT? Yes No

HAVE YOU EVER BEEN HOSPITALIZED? Yes No

HAVE YOU EVER SMOKED IN THE PAST? Yes No

ARE YOU CURRENTLY A SMOKER? Yes No

DO YOU TAKE MEDICATION ON A REGULAR BASIS? Yes No

HAVE YOU EVER BEEN TOLD YOU HAVE CANCER? Yes No