Riverbend Chiropractic and Wellness
608 Riverbend Square
Edmonton, AB T6R 2E3

Patient's Confidential Personal Record

Date	Alberta Heath Care Number

Last Name	First Name	Middle Name or Initial	Email Address(optional)

Address	City or Town	Province	Postal Code

Home Number	Work Number	Cell Number

Personal Information

What name do you prefer to be called?

Male ☐ Female ☐	Height	Weight

Birth Date (Y/M/D)

Marital Status	Spouse's Name

Emergency Contact

Parent or guardian's name, if under 18 years

How did you learn about our clinic?

Work Information

Occupation or type of work you do

Employer's Name

Is this a Worker's Compensation case?
Yes ☐ No ☐

Is this an auto accident case?
Yes ☐ No ☐

Health Insurance Information

Private health insurance provider

Private health insurance identification number

Private health insurance group number

What is causing you problems at this present time?

Have you had previous chiropractic or medical care for this condition?
Yes ☐ No ☐ If yes, when?

The information I have given above is correct to the best of my knowledge. I have also been advised of the fee schedule and policy.

Signature

Fees for the chiropractic services you receive are to be paid at the time of the appointment, unless special arrangements have been made.

If you have any questions, please ask the receptionist.

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibly being accepted for care.

Check any of the conditions you have *ever* had:

- ☐ Malaria
- ☐ Diabetes
- ☐ Cancer
- ☐ Mental Disorder
- ☐ Rheumatic Fever
- ☐ Chicken Pox
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mumps
- ☐ Alcoholism
- ☐ Diphtheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Influenza
- ☐ Scarlet Fever
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Small Pox
- ☐ Tuberculosis
- ☐ Polio
- ☐ Heart Disease
- ☐ Goiter
- ☐ Eczema

Check any of the following you *have or have had* in the past 6 months

Musculoskeletal

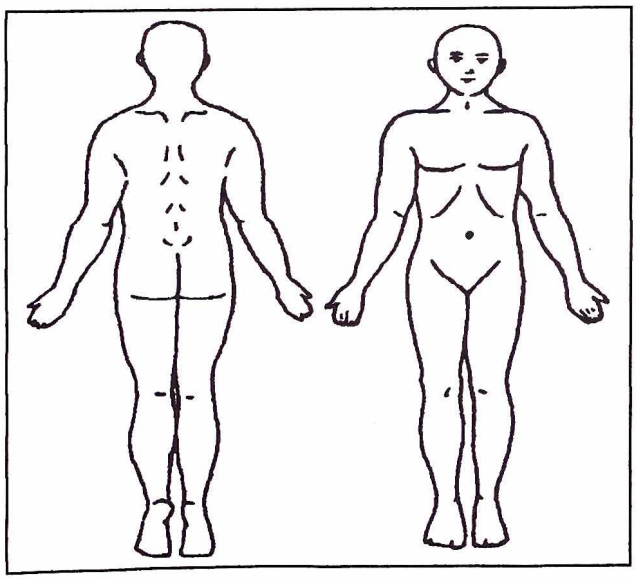
- ☐ Low Back Pain
- ☐ Pain between Shoulders
- ☐ Neck Pain
- ☐ Shoulder/Arm Pain
- ☐ Leg Pain
- ☐ Jaw Pain
- ☐ Walking Problems
- ☐ Joint Pain

Nervous System

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

Gastro-Intestinal

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Gas Bloating After Meals
- ☐ Black/Bloody Stool
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Liver Trouble
- ☐ Heart Burn
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Colitis



On the above diagram please outline the area of your problems.

Cardiovascular

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heart Beats
- ☐ Heart Problems
- ☐ Lung Congestion/Problems
- ☐ Varicose Veins
- ☐ Ankle Swelling

Male/Female

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate Dysfunction
- ☐ Genital Herpes

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- ☐ Bladder Troubles
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

General

- ☐ Allergies ☐ Fever
- ☐ Loss of Sleep
- ☐ Headaches

Eye/Ear/Nose/Throat

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulties
- ☐ Stuffed Nose

Females Only

Are you pregnant? ☐ Yes ☐ No ☐ Maybe

When was your last period? _____