DIAMOND VALLEY
CHIROPRACTIC & HEALTH CENTRE

Carrington – Morris Professional Corporation
205 Centre Avenue W., Black Diamond, AB. T0L 0H0

THE INFORMATION YOU PROVIDE IS FOR THE CONFIDENTIAL USE OF THIS OFFICE AND WILL ONLY BE RELEASED WITH YOUR WRITTEN CONSENT OR IF YOUR TREATMENT IS COVERED UNDER THE WORKER`S COMPENSATION ACT.

Health Insurance Company_____**Group/Policy#**_____

Member ID #_____

Date _____ AHC # _____ (X-ray Purposes)

Name _____

Mailing Address _____

Postal Code _____ Phone: H _____ B _____ C _____

Age _____ E-mail _____

How did you hear about us?_____

Would you like an appt. reminder**: Y N** If Yes, by: e-mail____text_____ cell phone provider _____

Birth Date (m/d/y)_____ Name of Spouse _____

Marital Status _____ Single _____ Married _____ Widowed _____ Divorced _____ Separated

Number of Children _____ Occupation _____

Is this a Worker's Compensation Case? NO _____ YES _____

If yes: Date of Injury _____ SIN _____

Is this a Personal Injury Case? NO _____ YES _____

If yes: Describe _____

Have You Had Previous Chiropractic Care? NO _____ YES _____

Name of Doctor _____ Address _____

What were you treated for? _____ Were X-Rays Taken? NO ____YES _____

What is your major complaint? _____

Do you have any other complaints? _____

Please list surgical operations and approximate dates they were performed _____

_____

Are you currently on any medication? _____

Name of Medical doctor? _____ Address _____

Have you ever been in an automobile accident? NO _____ YES _____

If yes: Describe _____

Do you or a family member have a history of any of the following?

___ HIV	___ Alcoholism	___ Allergies	___ Arthritis	___ Asthma	___ Cancer
___ Bed Wetting	___ Depression	___ Diabetes	___ Stroke	___ Heart Disease	___ Epilepsy
___ Multiple Sclerosis	___ Stomach Ulcers	___ Drug Addiction	___ Other	_____	

Please indicate if you have ever suffered from any of the following conditions

___ Appendicitis	___ Malaria	___ Chicken Pox	___ Alcoholism	___ Scarlet Fever
___ Tuberculosis	___ Diabetes	___ Venereal Disease	___ Diphtheria	___ Cancer
___ Arthritis	___ Whooping Cough	___ Typhoid Fever	___ Anaemia	___ Epilepsy
___ Heart Disease	___ Pneumonia	___ Measles	___ Goitre	___ Mental Disorder
___ Mumps	___ Influenza	___ Polio	___ Rheumatic Fever	___ Small Pox
___ Pleurisy	___ Eczema	___ Psoriasis	___ Stroke	___ Transient Ischemic Attack

Please indicate if you have experienced any of the following symptoms within the last year

___ Low Back Pain
___ Pain Between Shoulders
___ Neck Pain
___ Arm Pain
___ Walking Problems
___ Painful/Clicking Jaw
___ Numbness
___ Paralysis
___ Dizziness
___ Forgetfulness
___ Fainting
___ Convulsions
___ Cold/Tingling Hands/Feet
___ Allergies
___ Loss of Sleep
___ Fever
___ Night Pain
___ Night Sweats
___ Headaches
___ Poor/Excessive Appetite
___ Excessive Thirst
___ Nausea
___ Vomiting
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Liver Trouble
___ Gas/Bloating After Meals
___ Joint Pain/Stiffness

___ Heart Burn
___ Black/Bloody Stool
___ Colitis
___ Bladder Trouble
___ Painful/Excessive Urination
___ Discoloured/Bloody Urine
___ Chest Pain
___ Shortness of Breath
___ Blood Pressure Problems
___ Heart Problems
___ Lung Problems/Congestion
___ Varicose Veins
___ Ankle Swelling
___ Vision Problems
___ Dental Problems
___ Sore Throat
___ Ear Aches
___ Hearing Difficulties
___ Stuffed Nose

MEN ONLY
___ Prostate/Sexual Dysfunction
___ Genital Sores /Herpes

WOMEN ONLY
___ Menstrual Irregularity
___ Menstrual Cramping
___ Vaginal Pain/Infections
___ Breast Pain/Lumps
Are you pregnant? ___ yes ___ no
When was your last period? _____

A reminder that our office requires minimum 24 hours' notice to cancel or change an appointment. Any changes within 24hours is subject to a fee being charged to your account. _____initial here

Email and text message reminders are a courtesy, we ask that you add your appointments to your calendar to ensure you don't miss your appointment as sometimes our technology doesn't always connect with yours even though we try! _____initial here