Dr. Neil A. Burden
Chiropractor

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Doctors of Chiropractic are trained to detect and correct vertebral subluxation. Your response to this questionnaire will help us determine potential causes and effects of subluxation.

Please complete this confidential health questionnaire fully and accurately

Patient Information

Name_____

Permanent Address _____Unit #___

City_____ Prov _____ Postal _____

Telephone
Home_____ Cell _____

Work_____ Ext_____ Fax _____

Email_____

Birthdate_____ Age _____

Height _____ Weight _____

Gender □Male □Female Number of children____

Marital Status □ Single □ Married □ Separated
□ Divorced □ Common Law □Widowed

Name of Spouse/Significant Other

_____

Experience with Chiropractic Care

Who referred you to this office?

_____

Have you even been adjusted by another chiropractor □ Yes □ No
If yes, reason for the visits?

_____

Were X-rays taken □ Yes □ No

Did your family receive Chiropractic Care? □ Yes □ No

Chiropractor's Name

_____

Approximate date of last visit:

_____

What is the purpose of this appointment? _____
Is the purpose related to: □ Work □ Stress □ Sports □ Auto □ Fall □ Spinal check
□ Repetitive stress and strain □ Other_____

I have had this condition for _____ (time). I have had this or similar conditions in the past □ Yes □ No

The following activities aggravate my condition _____

This condition has □gotten worse □stayed constant □comes and goes

This condition interferes with □work □sleep □daily routine □childcare responsibilities □sports □studies

Have you seen any other health care provider for diagnosis or management of this condition? □ Yes □ No
Practitioner's name _____ Type of care _____
Results _____ Date _____

MY HEALTH CONDITIONS

Please circle each of the diseases or conditions that you have now or have had in the past. While some conditions may seem unrelated to the purpose of this appointment, they can affect the diagnosis, care plan, and the possibility of being accepted for care, or referred to another practitioner, if necessary.

General
Allergy
Convulsion
Dizziness
Fatigue
Headache
Loss of sleep
Loss of weight
Anxiety/depression
Numbness
Cancer
Diabetes
Thyroid problems
Epilepsy
Hyperactivity
Poor posture
Liver trouble

Women Only
Menstrual cramps
Excessive menstruation
Irregular cycle
Hot flashes
Are you pregnant
□ Yes □ No

Muscle and joint
Arthritis
Hernia
Low back pain
Neck pain
Pain between shoulder blades
Swollen joints
Gout
Polio

Numbness or pain in:
Shoulders
Arms
Hands
Legs
Feet

Eyes, Ears, Nose, Throat
Asthma
Frequent colds
Crossed eyes
Deafness
Ear infections
Ringing in ears
Eye pain
Vision problems
Nasal Obstruction
Sinus infection

Gastro-Intestinal
Constipation
Diarrhea
Digestive dysfunction
Gall bladder trouble
Hemorrhoids
Ulcers

Cardio-Vascular
High blood pressure
Low blood pressure
Poor circulation
Irregular Heart beat
Ankle swelling
Anemia
Arteriosclerosis
Stroke

Respiratory
Chest pain
Chronic cough
Irregular breathing
Wheezing
Emphysema

Genito-Urinary
Bed-wetting
Painful urination
Prostate trouble
Blood in urine
Venereal disease
Infection

Other (not listed) _____

History of Chemical and Personal Stress

Medications I am presently taking

□ Painkillers _____

□ Anti-inflammatory _____

□ Muscle relaxant _____

□ Blood pressure medication _____

□Stimulants, Anti-depressants _____

□Tranquilizers, Anti-anxiety _____

□Blood thinners _____

□Birth control pills _____

□ Other _____

Health Habits

	Heavy	Moderate	Light	None
Tobacco	□	□	□	□
Coffee	□	□	□	□
Alcohol	□	□	□	□
Recreational drugs	□	□	□	□
Exercise	□	□	□	□
Sleep	□	□	□	□
Appetite	□	□	□	□
Stress levels	□	□	□	□
Stress levels past	□	□	□	□

With respect to the questions below, please provide details where applicable, including dates:

Have you ever been knocked unconscious? □ Yes □ No _____

Have you ever had any fractures? □ Yes □ No _____

Have you ever had any impacts, falls or jolts? □ Yes □ No _____

Motor vehicle accidents? □ Yes □ No □ Passenger □ Driver

Sprains, strains, dislocations (approx. date) _____

Surgical operations (approx. date) _____

I wish to live #_____ YEARS OF LIFE

In the event that X-rays are necessary in my case, I understand and agree that X-rays taken in this office are the property of Dr. Burden and will remain in this office unless requested by another primary health care practitioner by written authorization.

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that fees for professional services are due when rendered. I understand that if I suspend or terminate my care, any fees for professional services rendered will become immediately due and payable. I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself.

_____ _____

Signature or Parent/Legal Guardian (I have read and understood the above) **Date**