PATIENT INTRODUCTION

DATE: _____ File # _____

WELCOME … to the chiropractic office of …

Dr. Alex J. Dougley, D.C.

348 King St. E, Cambridge, ON, N3H 3M8

Please complete this questionnaire **front and back.** Please **print** your answers. They will help us determine if Chiropractic can help you.

NAME: _____ **HOME PHONE:** _____

ADDRESS: _____ **WORK PHONE:** _____

_____ **MARTIAL STATUS:** _____
(city) (province) (postal code)

BLOOD TYPE: _____

Date of Birth: _____ **AGE:** _____ **Ages of children:** _____
(day) (month) (year)

Email: _____

WHAT IS YOUR MAIN COMPLAINT / SYMPTOMS ? _____

_____

How long have you had this condition ? _____ Have you had this condition before ? _____ WHEN ? _____

DOES THIS CONDITION **INTERFER** WITH YOUR: work _____ sleep _____ daily routine: _____ other (please explain): _____

WHEN IT'S AT ITS WORST, **HOW DOES IT FEEL ?** _____

WHAT MAKES IT **FEEL BETTER ?** _____ WHAT MAKES IT **FEEL WORSE ?** _____

WHAT DO YOU THINK IS THE **CAUSE** OF YOUR PROBLEM ? _____

_____

ANY **HEAD INJURIES** IN YOUR LIFE ? _____

OTHER CONCERNS? _____

FAVOURITE **EXERCISES?** _____ How Often Each Week? ____

TYPE OF BED ? _____ SLEEPING POSITION ? _____

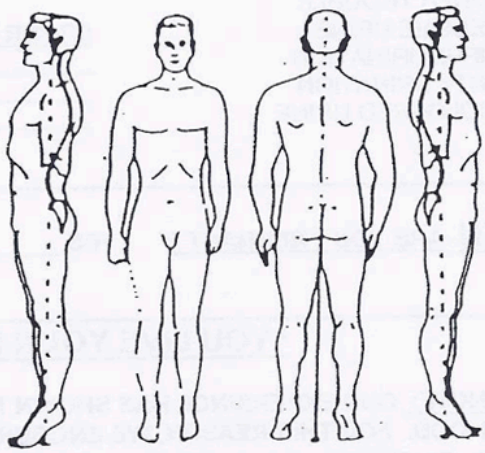
ANY CAR **ACCIDENTS** ? / WHEN ? _____

ARE THERE ANY FAMILY **HEREDITARY DISORDERS ?** IF YES, PLEASE EXPLAIN. _____

ARE YOU TAKING ANY **VITAMINS OR MINERALS?** IF YES, LIST HERE _____

_____

PLEASE MARK AN "X" WHERE IT HURTS



OCCUPATION/PLACE OF EMPLOYMENT: _____ ANY LIFTING ? _____

NAME OF SPOUSE: _____ OCCUPATION: _____

_____

HAVE YOU EVER HAD PREVIOUS CHIROPRACTIC CARE ? _____ IF YES, WHEN ? _____ SAME PROBLEM ? _____

CHIROPRACTOR'S NAME: _____ CITY? _____ DID CHIROPRACTIC HELP YOU ? _____

M.D's NAME: _____ PRESCRIPTIONS ? (list) _____ SURGERY ? _____ LASTVISIT? _____

_____

DID SOMEONE REFER YOU TO OUR OFFICE ?: _____ IF YES, NAME PLEASE: _____

NAME OF PERSON LEGALLY RESPONSIBLE (if the patient is a minor) _____

HEALTH QUESTIONNAIRE

PLEASE CHECK ANY SYMPTOMS YOU ARE EXPERIENCING NOW (*mark with a √*) AND ANY SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST (*mark with a X*).

MUSCULO-SKELETAL SYSTEM
___ LOW BACK PROBLEMS
___ PAIN BETWEEN SHOULDERS
___ NECK PROBLEMS
___ ARM PROBLEMS
___ LEG PROBLEMS
___ SWOLLEN JOINTS
___ PAINFUL JOINTS
___ STIFF JOINTS
___ SORE MUSCLES
___ WEAK MUSCLES
___ WALKING PROBLEMS
___ RUPTURES
___ BROKEN BONES

NERVOUS SYSTEM
___ NUMBNESS
___ LOSS OF FEELING
___ PARALYSIS
___ DIZZINESS
___ FAINTING
___ HEADACHES
___ MUSCLE JERKING
___ CONVULSIONS
___ FORGETFULNESS
___ CONFUSION
___ DEPRESSION

GENITO-URINARY SYSTEM
___ BLADDER TROUBLE
___ EXCESSIVE URINE
___ PAINFUL URINATION
___ SCANTY URINATION
___ DISCOLOURED URINE

GASTRO-INTESTINAL SYSTEM
___ POOR APPETITE
___ EXCESSIVE HUNGER
___ DIFFICULT CHEWING
___ DIFFICULT SWALLOWING
___ EXCESSIVE THIRST
___ NAUSEA
___ VOMITING FOOD
___ VOMITING BLOOD
___ ABDOMINAL PAIN
___ DIARRHEA
___ CONSTIPATION
___ BLACK STOOL
___ BLOODY STOOL
___ HEMORRHOIDS
___ LIVER TROUBLE
___ GALL BLADDER PROBLEMS
___ WEIGHT TROUBLE

CARDIO-VASCULAR-RESPIRATORY
___ CHEST PAIN
___ PAIN OVER HEART
___ DIFFICULT BREATHING
___ PERSISTENT COUGH
___ COUGHING PHLEGM
___ RAPID HEARTBEAT
___ BLOOD PRESSURE PROBLEMS
___ HEART PROBLEMS
___ LUNG PROBLEMS
___ VARICOSE VEINS

OTHER SYMPTOMS
_____
_____
_____

EYE, EAR, NOSE, THROAT
___ EYE STRAIN
___ EYE INFLAMMATION
___ VISION PROBLEMS (SPOTS/ BLURRING)
___ EAR PAIN
___ EAR NOISES
___ HEARING LOSS
___ EAR DISCHARGE
___ NOSE PAIN
___ NOSE BLEEDING
___ NOSE DISCHARGE
___ DIFFICULT BREATHING THROUGH NOSE
___ SORE GUMS
___ DENTAL PROBLEMS
___ SORE MOUTH
___ HOARSENESS
___ DIFFICULT SPEECH

FEMALES ONLY
___ VAGINAL DISCHARGE
___ VAGINAL BLEEDING
___ VAGINAL PAIN
___ BREAST PAIN
___ LUMPS ON BREAST

SIGNS OF SUBLUXATIONS
___ LOW ENERGY LEVEL
___ IRRITABILITY
___ LOSS OF SLEEP
___ MOOD SWINGS
___ SLUGGISH BOWELS
___ DISORIENTATION
___ BURNING SENSATIONS
___ SHARP, SHOOTING PAINS
___ BRAIN "FOG"

WOMEN- ARE YOU PREGNANT ? YES _____ NO _____ MAYBE _____ DATE OF LAST PERIOD _____

"YOU LIVE YOUR LIFE THROUGH YOUR NERVE SYSTEM"

PLEASE NOTE: OUR EXPERIENCE HAS SHOWN THAT MOST OF THE CONDITIONS WE FIND IN ADULTS ACTUALLY STARTED IN CHILDHOOD. FOR THIS REASON, WE ENCOURAGE YOU TO HAVE THE SPINES OF YOUR CHILDREN CHECKED.

WOULD CHECKING YOUR CHILDREN INTEREST YOU? YES____ MAYBE____ NO____

CHILDREN NAMES / AGES / ANY APPARENT SYMPTOMS OR "INCURABLE" CONDITIONS (I.E.: EARACHES, ASTHMA, SLEEPING AND LEARNING DISORDERS, FREQUENT COLDS, EAR & THROAT INFECTIONS, BAD FALLS, NEED FOR ANTI-BIOTICS, VENTALIN, BED WETTING, DEFIANCE, APATHY, POOR CONCENTRATION).

PLEASE READ AND SIGN THIS AGREEMENT. IT IS FOR YOUR PROTECTION.

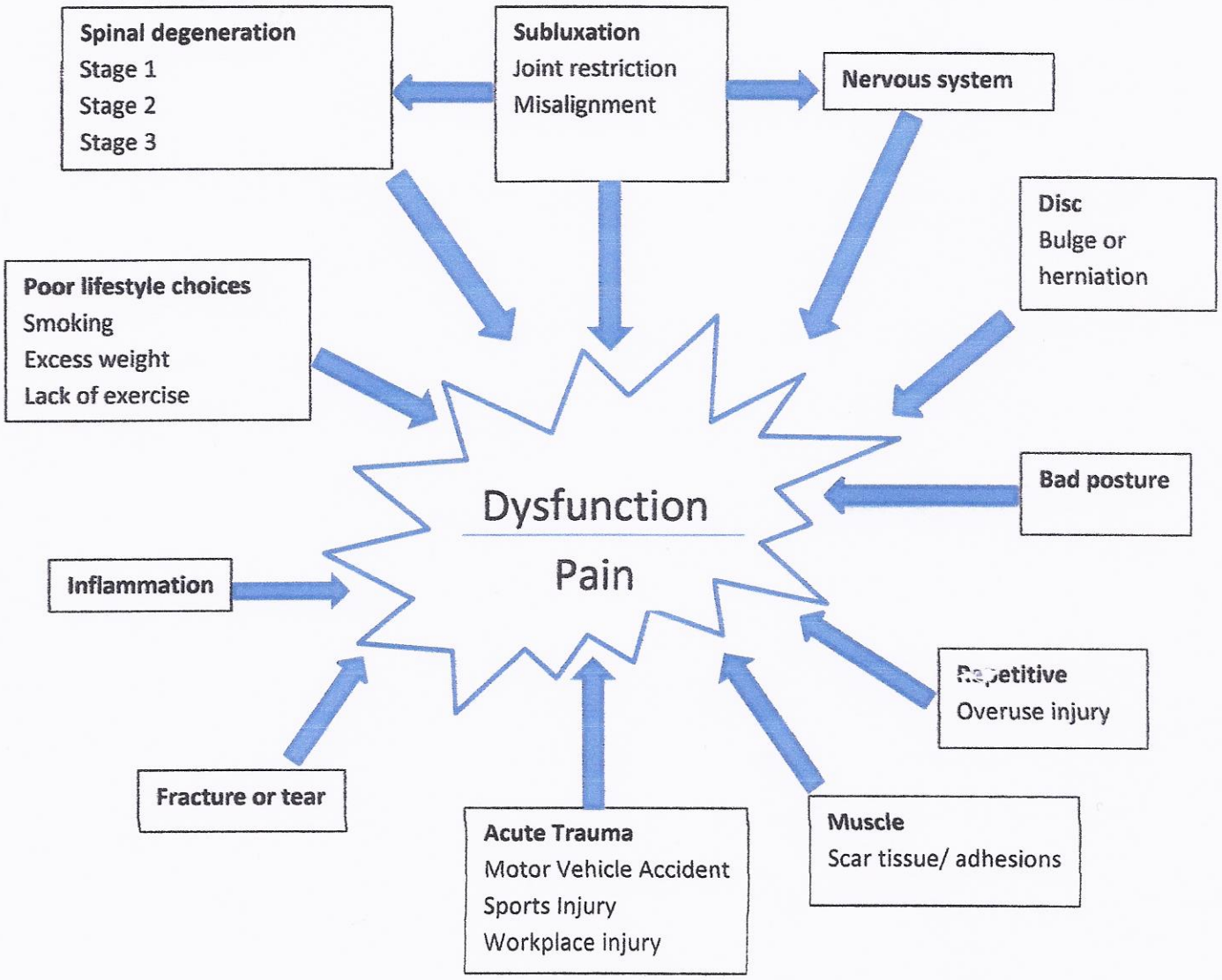
I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED WILL BE CHARGED TO ME DIRECTLY; SUPPLEMENTARY INSURANCE FORMS WILL BE FILLED OUT FOR A NOMINAL FEE; I UNDERSTAND FEES ARE PAYABLE AT THE TIME THE SERVICE IS RENDERED (as per agreement with staff).

SIGNATURE: _____

(if patient is a minor, name of parent or legal guardian)

"The Power That Made The Body HEALS The Body"

Where is my problem coming from?



Dr. Alex J. Dougley D.C.
348 King St. E.
Cambridge, ON N3H 3M8
(519) 653-7872
drdougley.com