CHERRYHILL
CHIROPRACTIC

Dr. Scott Watson

Patient Information (Please Print)

Name:_____Gender:_____

Address:_____ City:_____

Province:_____ Postal Code:_____Home Phone:_____ Cell Phone:_____

Birth Date (D/M/Y):____/_____/____ Age:_____ Marital Status: ☐ S ☐ M ☐ D ☐ W

Email_____

Emergency contact:_____ Phone Number:_____

Have you attended another chiropractor? ☐ Y ☐ N Name:_____

Last seen (D/M/Y):____/_____/_____ Reason for visit:_____

Refferred by:_____

Employer Information

Employer:_____ Occupation:_____

_____

Insurance company Policy # (Plan certificate #) Member ID # (member certificate #)

Physician Information

Medical Doctor:_____City:_____Phone:_____

Date of last physical (D/M/Y):_____/_____/_____

May we contact and/or send medical information to your medical doctor? ☐ Y ☐ N

Cherryhill Chiropractic
101 Cherryhill Blvd. Suite 203
London, ON N6H 4S4
T:519-433-7281 F:519-433-9504

Information of Condition

What is the main reason for this visit?_____

When did this problem start?_____How?_____

Any additional complaints?_____

On the diagram below, please indicate where you are experiencing pain now and use the appropriate symbol as indicated

Ache ////////////

Burning BBBBB

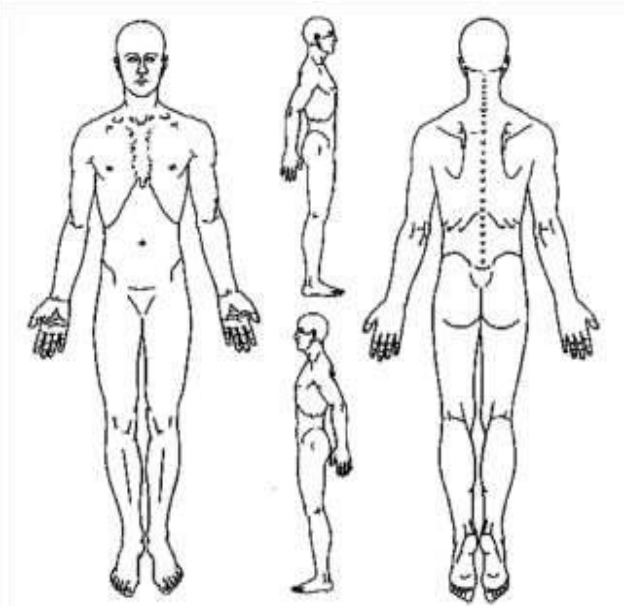
Numbness NNNNN

Pins & Needles ++++++

Stabbing XXXXX

Stiffness ^^^^^^^^

Weakness WWWW



Please make a slash through this line to the level of your current pain

No pain at all |----------| Worst Pain Possible

The symptoms are (Please Circle): Constant Intermittent Worse with movement Better with movement

Worse in the a.m. Worse in the p.m. Getting better Getting worse No change

I am experiencing (Please Circle): Numbness Weakness Swelling Weight changes Night Sweats

Fever Changes in bowel/bladder frequency or urgency

What makes your symptoms worse? (Please Circle): Standing Walking Lifting Exercise

Twisting Bending Sitting Coughing/Sneezing Lying Down: Side Back Stomach

Using Stairs: Up Down Both Other: _____

What makes your symptoms better? (Please Circle): Rest Elevation Ice Heat

Position: _____ Other: _____

Medications/Vitamins/Supplements:_____

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Past Medical History

Have you ever been in an automobile accident? ☐ Y ☐ N Date: _____

Any difficulties/injuries resulting from this incident?_____

Please list surgeries and year performed:_____

Please indicate if you have every had any of the following?

Cardiovascular

- ☐ High/Low Blood Pressure
- ☐ Heart Attack
- ☐Stroke
- ☐Aneurysm
- ☐Pace Maker
- ☐Heart Disease
- ☐Other:_____

Infection

- ☐Hepatitis
- ☐TB
- ☐HIV
- ☐Skin
- ☐Chicken Pox
- ☐Other:_____

Previous Injuries

- ☐Head/Neck
- ☐Upper Back
- ☐Mid Back
- ☐Lower Back
- ☐Shoulders/Arms
- ☐Wrist/Hands/Fingers
- ☐Pelvis
- ☐Legs/Knees
- ☐Ankles/feet/toes

Other Conditions

- ☐Diabetes
- ☐Cancer
- ☐Arthritis: OA/RA
- ☐Osteoporosis
- ☐Epilepsy
- ☐Psoriasis
- ☐Fibromyalgia
- ☐Fatigue
- ☐Concussion
- ☐Allergies:_____
- ☐Other:_____

Respiratory

- ☐Shortness of Breath
- ☐Asthma
- ☐Bronchitis
- ☐Emphysema/COPD
- ☐Pneumonia
- ☐Other:_____

Head/Neck

- ☐Headaches
- ☐Migraines
- ☐Vision Problems
- ☐Hearing Problems
- ☐Sinus Condition
- ☐Other:_____

Women

Are you currently pregnant? ☐ Y ☐N

If yes,
due Date:_____

Signature: _____ Date: _____

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