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DATE: M/D/Y: ___/____/_____
Dr.'s Caitlin Lubberdink & Mitch Badz

THE CHIROPRACTIC HOUSE & CO,
New Patient Paperwork- Adult

PERSONAL HISTORY

Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: (_____)_____ Birth date: ____/____/____(mm/dd/yy) ❑ Male ❑ Female ❑Undisclosed
Occupation: _____ Business / Employer: _____
Business Phone: (_____)_____ Extended Health Coverage: _____
Marital Status (Please check one): ❑Married ❑Single ❑ Widowed ❑ Divorced ❑ Separated ❑ Other No. of Children: _____
Mobile Phone: (_____)_____ Name of Emergency Contact: _____
Emergency Contact's Relationship: _____ Phone Number For Emergency Contact: (_____)_____
Referred To This Office By: ❑ Website ❑ RMT ❑ Patient/Dr. (name): _____
Email Address: _____

CURRENT HEALTH CONDITIONS

Current Complaint(s): _____
Other Doctors seen for this condition?❑ Yes ❑ No If yes, Who? _____
Type of Treatment: _____ Results: _____
When did this condition begin? _____ Has this condition occurred before? ❑ Yes ❑ No
What aggravates your condition? ❑ Sitting ❑ Standing ❑ Bending ❑ Lifting ❑ Walking ❑ Lying Down
❑ Cold ❑ Dampness ❑ Other: _____
What relieves your condition? ❑ Bed Rest ❑ Ice ❑ Heat ❑ Massage ❑ Medication
❑ Other: _____
Is it getting: ❑ Worse ❑ Constant ❑ Better ❑ Comes and Goes
Character of Pain: ❑ Sharp ❑ Dull ❑ Ache ❑ Numb ❑ Burning ❑ Pins and Needles
Please describe the problem at its worst: _____
_____
When the problem is at its worst does it interfere with:
Your ability to work?_____
Your ability to enjoy family / social time?_____
Your ability to enjoy sports or hobbies?_____
If it isn't corrected, do you think this will get worse over the next 5 years? ❑ Yes ❑ No
Drugs you now take: ❑ Nerve Pills ❑ Insulin ❑ Pain Killers ❑ Muscle Relaxant ❑ Blood Pressure Medication
❑ Others: _____
Do you suffer from any other condition(s) other than that for which you are now consulting us? ❑Yes ❑No
If yes, describe: _____
On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: _____
Have you had x-rays taken in the last 6 months? ❑ Yes ❑ No If yes, where? _____

PAST HEALTH HISTORY

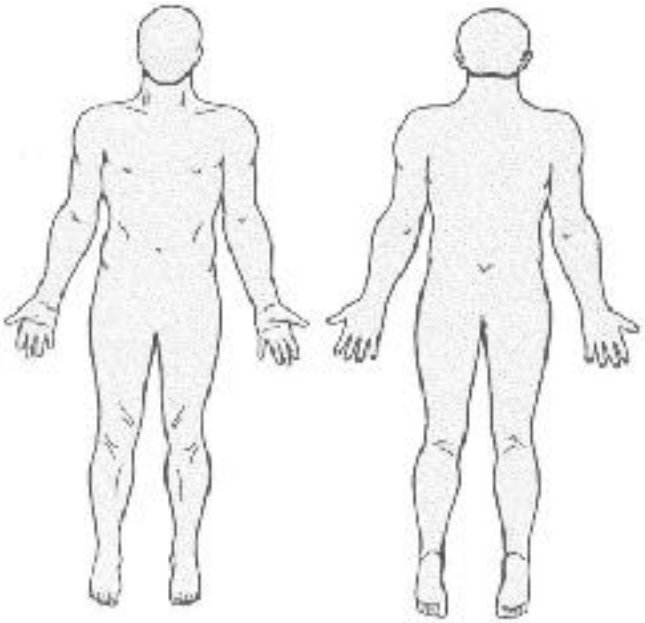
Major Surgery / Operations: ❑ hip replacements ❑ knee replacements ❑ fractures ❑ Hernia ❑ Shoulder Surgery
❑ Spinal Surgery. ❑ Other:_____

Major Health Conditions: ❑ heart attack/heart issues ❑ cancer ❑ stroke ❑ diabetes ❑ blood pressure ❑ other _____
Major Accidents (MVA) or Falls: _____
Hospitalization /Infectious Diseases(other than for above): _____
Previous Chiropractic Care: ❑ None ❑ Doctor's name and approximate date of last visit: _____

FAMILY HEALTH HISTORY

Does any family member suffer from this same condition or other spinal conditions? ❑ No ❑ Yes; Explain _____
Have your children ever had a spinal check up? ❑ Yes ❑No If yes, where and when? _____

Please OUTLINE ON THE DIAGRAM the area of your pain/discomfort.



Everyday Stressors (0-10 0 being none, 10 being the worst possible score)

- Please Rate your current **everyday stress** level:
  no stress 0 1 2 3 4 5 6 7 8 9 10 absolute worst stress

- Please Rate your **work stress** level
  no stress 0 1 2 3 4 5 6 7 8 9 10 absolute worst stress

- Self Perceived Posture
  perfect 0 1 2 3 4 5 6 7 8 9 10 worst posture

Amount of time spent at a desk (work/leisure)
❑ 10+ hours a day ❑ 7-9 hours a day ❑ 5-7 hours a day ❑ Approx. 4 hours a day ❑ Less than 2 hours a day

Regular Exercise routine
❑ No ❑ Yes 1-2 X a week ❑ Yes 3+ X a week

Office Policies Please Initial Below

_____I agree to the DC's discussing with other health practitioners at the Chiropractic House & Co health concerns related to my chief complaint.
_____I agree to DC's releasing proof of attendance and payment information to 3rd party benefit and insurance companies.
_____ I Consent to the DCs performing a physical exam to further evaluate my case