GELLEY CHIROPRACTIC OFFICE

Date: ___________________

Name: ____________________|_______________|____
(Surname) (First) (Initial)

Preferred Name: _____________

Sex (as listed on MH card): M F

Address: ____

Home Phone: _______________

Cell Phone: _________________

City: _____________ Prov: ____ Postal Code: ________

Work Phone: _______________

E-Mail: ____________________

____

Date of Birth: _____________________ Age: ________
(d) (m) (y)

MHSC: ______________ PHIN__________________
(6 digit) (9 digit)

Parent/Guardian: _____________
(for children under 18)

Place of Employment: ____

Employment Address: ____ City: ____________

Occupation/Profession/Type of work: ____

Have you been treated by a chiropractor before? Yes / No When: _____________________

If yes, name of previous chiropractor: ____

Name of Medical Doctor: ____

Date of Last Medical Examination: __________________ Clinic Name: ___________________

Do you have reason to believe you may be pregnant? Yes _____ No _____ Possibly _______

X-ray, CT Scan, MRI in the last 2 years? Yes ____ (area)_____________________ No _____

List any surgeries and fractures: ____

Current illnesses or diseases: ____

List any medications/supplements that you are presently taking: _______________________

____

Do you have the following?

• A history of cancer?	Yes	No
• Unexplained weight loss?	Yes	No
• Night pain, unrelated to movement?	Yes	No
• Severe fever or chills?	Yes	No
• A recent bacterial infection?	Yes	No
• Prolonged steroid use?	Yes	No
• Osteoporosis?	Yes	No
• Arm or leg weakness that is getting worse?	Yes	No
• A pacemaker?	Yes	No

If you have answered yes to any of the above, please provide further information:

____

How did you hear about the Gelley Chiropractic Office?

Family/Friend ________________ Doctor__________________ Live in the area_________________

Mall sign_________ Website_________ Google____________ Other _____________________

GENERAL HEALTH QUESTIONNAIRE

Please indicate which of the following may apply

GASTRO-INTESTINAL

____excessive appetite
____difficulty swallowing
____excessive thirst
____heartburn
____excessive gas
____excessive bleeding
____frequent nausea
____vomited blood
____ulcers
____frequent vomiting
____intestinal infections
____red or tar colored stools
____hemorrhoids
____frequent diarrhea
____frequent constipation
____weight gain/loss
____diabetes
____irregular bowel movements
____indigestion

MUSCULO-SKELETAL

____low back problems
____pain between shoulders
____neck problems
____arm pain
____swollen joints
____leg pain
____stiff joints
____muscle cramps
____muscle weakness
____walking problems
____ruptures (hernias)
____broken/fracture bones
____dislocations
____bone diseases
____other_______________

FEMALES ONLY

____menopause
____discharge from nipple
____lumps in the breasts
____breast pain
____vaginal discharge
____abnormal menstruation
____painful periods
____contraceptives
____pregnancies#
____other________________

CARDIO-VASCULAR

____racing heart beat
____swelling of feet/ankles
____varicose veins
____fainting spells
____blood pressure problem
____cramps in legs
____poor circulation
____jaundice
____anemia
____stroke
____other___________

RESPIRATORY

____constant cough
____excessive phlegm
____coughing up blood
____asthma
____frequent bronchitis
____wheezing
____smoker

NERVOUS SYSTEM

____clumsy hands or gait
____tremors
____numbness
____loss of feeling
____paralysis
____dizziness
____fainting
____frequent headaches
____muscle twitching
____convulsions/seizures
____forgetfulness
____confusion
____depression
____other____________

GENITO-URINARY

____irregular urination
____painful urination
____bladder infection
____excessive urination
____scanty urination
____discoloured urine
____unable to hold urine
____kidney stones
____can't empty bladder completely
____change in stream

EYES

____blurring
____bothered by light
____infection
____loss of vision
____cataracts
____other____________

EARS

____pain
____hearing loss
____ringing in ears
____discharge from ear
____infections
____other___________

NOSE

____discharge
____sinus problems
____other__________

MOUTH

____bite plate for jaw
____gum disease
____bleeding gums
____swollen gums
____painful gums
____change in taste
____other______________

THROAT

____hoarseness
____frequent sore throat
____difficulty swallowing

SKIN

____rashes
____coloration changes
____lumps
____bruise easily
____other________________

***I affirm and certify that all the information and answers to questions herein are complete, true, and correct to the best of my knowledge and belief*. x_______________________________**