Patient Introduction

Personal History:

Your Name: ____
First Middle Last

Your Address: _
____
____
____

Telephone: Home:____________________________ Bus: _____________________

Cell:______________________________

email Address: ____
(So we can send you our newsletter)

Birth Date: Day: _____________ Month: ________________ Year: ____________

Marital Status:____

Occupation: ____

Employer: _______________ ____

Previous Chiropractor: ________________________________ City: ________________

Last visit to this Chiropractor:____

Reason for leaving:
____
____
_________________ ____
____

Present MD: ____ City: ________________

Referred to our Centre by:___
____

Dr William Werner DC

Adult Consultation History

Your Name: ____
____
Your Main Complaint: ____
____
Any other Complaints: ____

How long have you suffered with this problem? ______________________________
What have you tried to do to get rid of this problem that **DID NOT** work? ______________________
____

____
What do you do that makes this problem worse? ______________________________

____
____

What gives you some temporary relief? ______________________________

____
What is the pattern of this problem? Constant ___, Intermittent ___, Occasional ___ Cyclic ___

What is the effect it has on your body functions? ______________________________
____

____
How did it start? ____
____
Are you on any type of medication?___________, Please list all: ______________________________
____

____

____
Could your problem have been caused by an injury at work?______________________________
If yes, please give us the details: ______________________________
____
____
____

Have you been involved in an auto accident? ______________________________

Date of accident: ______________________________

Any difficulties from this?______________________________
____
____
____

Is there any other information you would like us to know?______________________________
____
____

SIGNATURE: ______________________________ DATE: ______________________________