`

DATE: _____

CONFIDENTIAL PATIENT INFORMATION
DR JAMES LAMONTAGNE, DR MELANIE CHAN & DR MATTHEW JACKSON
150 LOCKE STREET SOUTH, HAMILTON, ON L8P 4A9
(Please Print)

Please complete this questionnaire. Your answers will help us determine if chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.
Thank you.

Name: _____

Address: _____ City: _____

Postal Code: _____ Phone: (H) _____ (W) _____

Cell Phone: _____ Pager: _____ Email: _____

Age: _____ Date of Birth: (DD/MM/YY) _____ Gender: Male____ Female ___

Occupation: _____ Where: _____

Children: □ Yes □ NO Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Spouse: □ Yes □ NO Name: _____

Family Physician _____ Phone: _____

Last Visit: _____ Reason: _____

Have you had any previous chiropractic care? □ Yes □ NO
If yes, what was the chiropractor's name? _____
And when was your last visit? _____

Have you had Back or Neck X-rays taken? □ Yes □ NO
If yes, where and when? _____

If this a Personal Injury case: □ Yes □ NO
Is this a Motor Vehicle case: □ Yes □ NO
Is this a Workers' Compensation case: □ Yes □ NO

How did you hear about our office? _____

1. What is your major complaint? _____
2. How did this problem start? _____
3. How long have you had this condition? _____
4. Have you had this or similar conditions in the past? □ Yes □ NO
5. Is this condition getting progressive worse? □ Yes □ NO

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6. What activities aggravate your condition? _____

7. What relieves your condition? _____

8. Is this condition interfering with your: Work □ Yes □ NO
   Sleep: □ Yes □ NO Daily Routine □ Yes □ NO
   Other □ Yes □ NO

9. Have you had any treatment for this complaint prior to coming to this office? □ Yes □ NO

10. Do you have any secondary complaints? □ Yes □ NO

11. How long has it been since you really felt good? _____

12. Please circle if you had or are presently being treated for:

Allergies	Blood Pressure	Heart	Ulcers
Cancer	Diabetes	Stroke	Arthritis
Osteoporosis	Stress	Pacemaker	

Other _____

13. Drugs you now take: Aspirin □ Tylenol □ Advil/Ibuprofen □

Muscle Relaxants □ Pain Killers □ Birth Control Pills □ Hormone Therapy □

Blood Pressure □ Blood Thinners □ Anti-Depressants □ Tranquilizers □

"PEP Pills □ Other(s) □ _____

14. List all surgical operations: _____

15. How much coffee. Pop or tea do you consume on an average daily basis?

16. Do you smoke? □ Yes □ NO How much? _____

17. Have you ever been knocked unconscious? □ Yes □ NO

18. Have you ever had a fractured bone? □ Yes □ NO

19. Have you been prescribed or do you wear: Foot Orthotics □ Yes □ NO
    Heel Lifts □ Yes □ NO Insoles: □ Yes □ NO Other: _____

20. What do you like to do in your spare time, hobbies, activities?

    _____

21. Present reasons for consulting this office:
    1. Pain relief _____
    2. Correction of Underlying Problem(s) _____
    3. Spinal Maintenance Care _____
    4. General Health Evaluation _____
    5. Annual Spinal Checkup _____
    6. Other _____

22. Is there anything you would like to add or ask at this time? _____
    _____