



Dr. Stacy Larsen
Doctor of Chiropractic
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403-340-0278

CONFIDENTIAL PATIENT INFORMATION

Date _____

Name _____ AHC# _____ Home Phone _____

Address in full _____ Postal Code _____ E-mail _____

Occupation _____ Office phone _____ Fax _____

Birthdate M/ ___ D/ ___ Y/ ___ Male ___ Female ___ Married ___ Single ___ Other ___ How many children? ___

Name of Spouse _____ Occupation _____ Phone _____

Nearest relative _____ Address _____ Phone _____

Whom may we thank for referring you to our office? _____

What is the purpose of your appointment? _____

What Area? *Neck Mid Back Low Back Hips Other* _____ Date symptoms appeared? _____

How intense is the pain? *Mild Moderate Severe* Where? *Left Middle Right Front Back Other* _____

How would you describe the pain? *Sharp Dull Achy Burning Stabbing Deep Shooting Other* _____

Does your condition? *Come and Go* Or is it? *Constant* How did it start? *Gradually Suddenly*

What aggravates your condition? *Stress Activity Lifting Standing Sitting Bending Work Turning Other* _____

What relieves your condition? *Rest Heat/Ice Lying Adjustment Massage Standing Sitting Other* _____

Is this condition interfering with your *Quality of Life Work Sleep Other* _____

Other Doctors/Professionals seen for this condition? _____

Have you been treated for any health conditions in the last year? *Yes No* Describe _____

Medical Doctor _____ Date of last physical exam _____ Purpose _____

Female: Are you pregnant? *Yes No Unsure*

What over the counter or prescription drugs are you taking? _____

Family History of Disease _____

Past History

What operations have you had? _____

Illnesses Current or Past? _____

Have you ever been hospitalized? _____

Broken/Fractured bones? *Yes No* Which ones _____

Have you ever been under Chiropractic Care? *Yes No*

Chiropractor's Name _____ Last time you saw Him/Her _____

I am double sided...

Are You Suffering From or Have You Ever Suffered From any of the following? Please Circle

Allergy / Hay Fever	Low Back Pain	Tuberculosis	Itching
Dizziness	Neck Pain / Stiffness	Pleurisy	Psoriasis / Eczema
Fatigue	Poor Posture	Bruise Easily	Bed-wetting
Headache / Migraines	Sciatica	Nosebleeds	Frequent Urination
Loss of sleep	Spinal Curvatures	Sinus Infection	Kidney Infection / Stone
Ulcers	Swollen Joints / Ankles	High/Low Blood Press.	Prostate Trouble
Nervousness / Depression	Colon Trouble	Heart Disease	Heavy Menstrual Flow / Cramps
Asthma	Difficult Digestion	Pain Over Heart	Irregular Cycle
Arthritis	Hemorrhoids	Poor Circulation	Hot flashes
Bursitis	Nausea	Rapid / Slow Heartbeat	Lumps In Breast
Foot Trouble	Diabetes	Anemia	Cancer
	Colds	Stroke	Venereal Disease
Tingling or numbness in:	Deafness	Chest pain	Polio
Shoulders Hips	Ear Noises	Difficulty Breathing	AIDS/HIV Positive
Arms Legs	Enlarged Thyroid	Alcoholism	Chronic Fatigue Syndrome
Elbows Knees	Eye Pain / Failing Vision	Hypoglycemia	Fibromyalgia
Hands Feet			

Circle your level of stress: **Home** - High Medium Low **Work** - High Medium Low

Habits	Heavy	Moderate	Light	None
Alcohol	___	___	___	___
Coffee	___	___	___	___
Tobacco	___	___	___	___
Exercise	___	___	___	___
	over 8 hrs.	6-8hrs.	under 6 hrs.	
Sleep	___	___	___	

Are you wearing? Heel lifts ___
 Inner soles ___
 Arch supports ___

PAYMENT IS EXPECTED AT TIME OF VISIT!

Name of person responsible for payment _____

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered will be immediately due and payable.

I understand that Chiropractic does not treat the disease or symptoms but uses them to ascertain where the specific adjustment(s) is/are needed. Chiropractic only attempts to adjust vertebrae, restoring the nerve impulse to the involved tissue, thus allowing the body its best chance of healing itself. I give the doctors and assistants at Larsen Family Chiropractic full permission to render care to myself and/or my family.

Patient's Signature _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____ Date _____