DR. R.D. CAMPANA/DR.K.A.CAMPANA, 426 BRUCE ST., SAULT STE. MARIE, ON 7052568112

Medical History Information

Last Name:

First Name: Middle: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.

Marital status (circle one)
Single / Mar / Div / Sep / Widow/ Com.Law

Email: Birth date: Age: Sex:

Address: City: Province:

Postal Code: Social Insurance No.: Home Phone:

Occupation: Employer: Business phone:

Medical Care Information

Do You Have a Family Doctor?: ☐ No ☐ Yes, Name of Doctor:

List Medications:

Date of last Visit: / / Date of last exam: / /

Have you had chiropractic care before?: ☐ No ☐ Yes, Were results satisfactory? ☐ No ☐ Yes

Is this a Workers Compensation Case? ☐ No ☐ Yes Is this related to a motor vehicle accident ☐ No ☐ Yes

Have you had any surgeries?: ☐ Yes ☐ No If yes, Last Surgery Date:

Reason for Surgeries:

Present illness /Conditions:

☐ AIDS	☐ Cancer	☐ Heart Problem	☐ Multiple Sclerosis	☐ Spinal Disc Disease	
☐ Allergies	☐ Cirrhosis/hepatitis	☐ High/low blood pressure	☐ Pacemaker	☐ Thyroid trouble	☐ Epilepsy
☐ Anemia	☐ Diabetes	☐ Ankle/knee/feet pain	☐ Prostate trouble	☐ Tuberculosis	☐ PMS
☐ Arthritis	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Ulcer	☐
☐ Asthma	☐ Diverticulitis	☐ Fibromyalgia	☐ Scoliosis	☐ Polio	☐
☐ Bone fracture	☐ Hay Fever	☐ Mental/ Emotional Difficulty	☐ Sinus trouble	☐ STD'S	☐

Other:

Family History of illness:

☐ AIDS	☐ Cancer	☐ Multiple Sclerosis	☐ Spinal Disc Disease	☐ STD'S	
☐ Allergies	☐ Bone fracture	☐ Heart Problem	☐ Low Blood Pressure	☐ Sinus trouble	☐ Ulcer
☐ Anemia	☐ Cirrhosis/hepatitis	☐ HIV/ARC	☐ Mental/ Emotional Difficulty	☐ Epilepsy	☐ Polio
☐ Arthritis	☐ Diabetes	☐ High blood pressure	☐ Prostate trouble	☐ Thyroid trouble	☐ Scoliosis
☐ Asthma	☐ Dislocated joints	☐ Kidney trouble	☐ Rheumatic fever	☐ Tuberculosis	☐ Diverticulitus

Other:

Social History:

Alcohol? ☐ No ☐ Yes Drinks per week?

Cigarettes? ☐ No ☐ Yes Cigarettes per day?

Caffeine? ☐ No ☐ Yes Drinks per day?

Exercise? ☐ No ☐ Yes Hours per week? (circle one) Light / Moderate / Strenuous

Misc.:

Signature: _____ Date: _____

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Pain Chart Name _____ Date _____

Major Complaints and symptoms-(Please be as specific as you can)_____

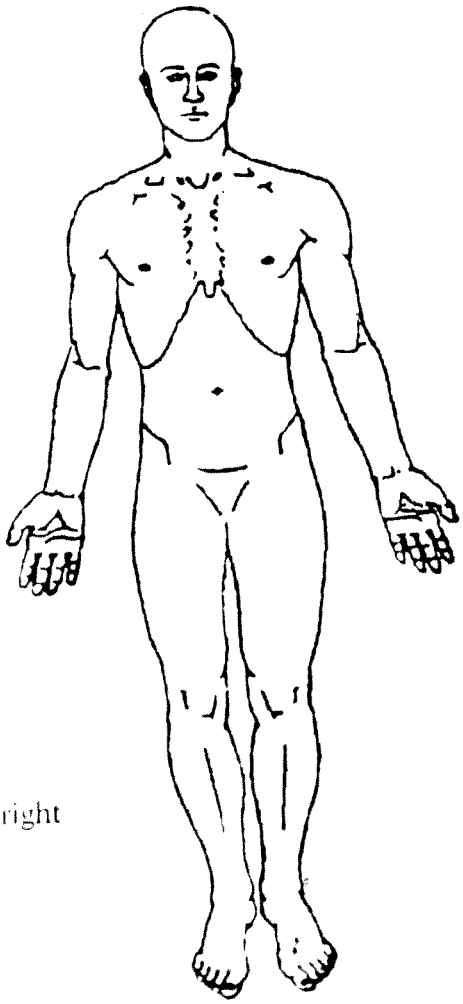
_____

_____

On Body Chart Below:

Please mark pain areas (use this symbol xxxxxx).

Please mark any scars you have (use this symbol +++++).



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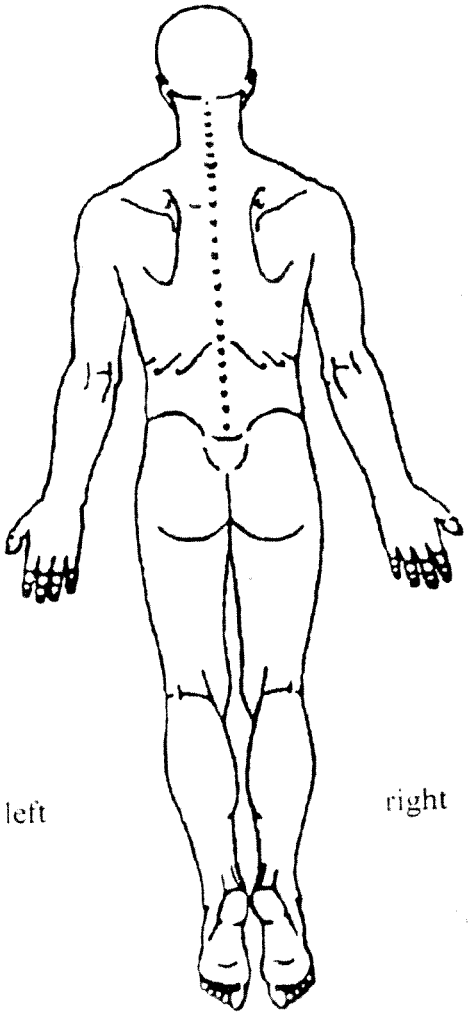

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