Recommendations to New Patients

During your initial visit to our office, you will receive a physical examination and a diagnostic examination. Your diagnostic examination will include a bilateral skin temperature scan, and/or a stress analysis.

In order to obtain the most accurate diagnostic results, please follow these simple instructions:

Proper Attire

- Indoor shoes (no flip flops)
- Comfortable loose clothing
- Remove all jewelry from the neck up ie: necklaces, ear rings, facial piercing
- Bring a clip or elastic if you have long hair

Pain Medications: No pain medications for 4 hours prior to your chiropractic visit.

Caffeine Drinks: No coffee, tea, chocolate, pop…caffeine free drinks are approved.

Alcohol: No alcohol for 4 hours prior to your chiropractic visit.

Smoking: No smoking for 1 hour prior to your chiropractic visit.

YOUR LIFE REVIEW

Patient Name: _____ **M F** **Number:** _____

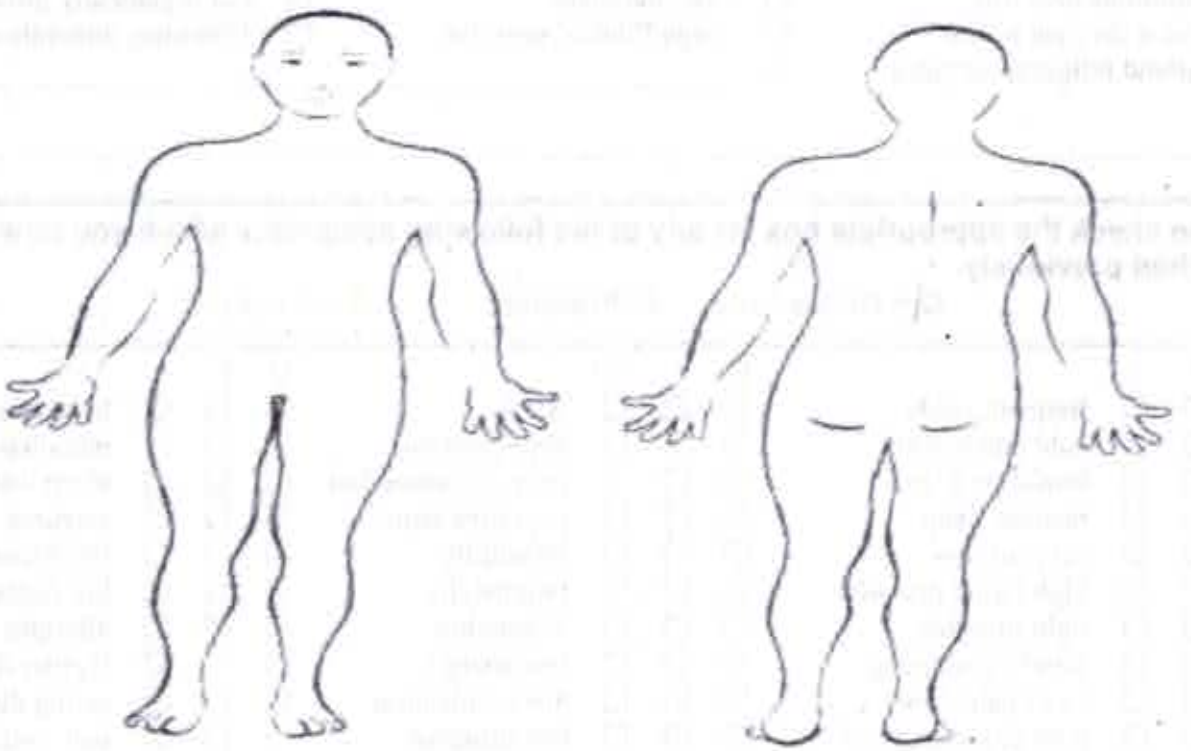
Current Health Challenge Information

Describe the pain: ☐sharp ☐dull ☐travels ☐constant
Since the onset, is the pain: ☐worse ☐better ☐the same ☐on & off
What makes it worse: ☐standing ☐sitting ☐lying ☐motion ☐other
What releives it: ☐standing ☐sitting ☐lying ☐motion ☐other
Does the pain cause you to: ☐lose sleep ☐be short tempered ☐miss work ☐miss play ☐lose focus
Are any of your systems involved: ☐digestive ☐cardiovascular ☐respiratory ☐elimination ☐reproductive
Are you a smoker: ☐ Yes ☐ No

Any other facts about your current condition: _____

_____

Place an X on the number indicating the severity of your condition: Least ①②③④⑤⑥⑦⑧⑨⑩ Worst



List current medications : _____

_____

_____

James A. Aldridge, D.C.
13-322 Argyle St. S., Caledonia, ON N3W 1K8 *T: 905-765-4025* *F: 905-765-4026*

Patient Name: _____ **M F** **Number:** _____

INJURY HISTORY

Do you play sports? ☐ Yes ☐ No What sports? _____

Have you ever broken a bone? ☐ Yes ☐ No Which ones?

_____

Have you ever been knocked out? ☐ Yes ☐ No

Have you ever been in a motor vehicle accident? (please note type and year, even if not apparently injured)

_____

List all surgeries and dates: _____

_____

Things I currently do to support my health include:

☐ Drink plenty of water	☐ Alcohol in moderation	☐ Maintain the proper weight
☐ Exercise regularly	☐ Get plenty of rest	☐ Maintain positive attitude
☐ Counseling/therapy	☐ Annual Physical Exams	☐ Self-improvement books
☐ Orthotics/heal lifts	☐ Pray/meditate	☐ Eat organically grown foods
☐ Use a cervical pillow	☐ Yoga/Pilates/Aerobics	☐ Vitamins, minerals or herbs
☐ Attend religious services	☐ _____	

_____

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

O = Occasional F=Frequent C= Constant

O	F	C		O	F	C		O	F	C	
☐	☐	☐	frequent colds	☐	☐	☐	ADD	☐	☐	☐	headaches
☐	☐	☐	cold hands/feet	☐	☐	☐	hypoglycemia	☐	☐	☐	narcolepsy
☐	☐	☐	bowel problems	☐	☐	☐	poor concentration	☐	☐	☐	sleep walking
☐	☐	☐	restless sleep	☐	☐	☐	cognitive worry	☐	☐	☐	seizures
☐	☐	☐	nervousness	☐	☐	☐	irritability	☐	☐	☐	Pre Menstral Syn
☐	☐	☐	high blood pressure	☐	☐	☐	impulsivity	☐	☐	☐	hot flashes
☐	☐	☐	tight muscles	☐	☐	☐	distraction	☐	☐	☐	allergies
☐	☐	☐	accelerated aging	☐	☐	☐	low energy	☐	☐	☐	bipolar disorders
☐	☐	☐	heart palpations	☐	☐	☐	disorganization	☐	☐	☐	eating disorders
☐	☐	☐	poor expressions of emotion	☐	☐	☐	incontinence	☐	☐	☐	bed wetting
				☐	☐	☐	muddledness	☐	☐	☐	mood swings
☐	☐	☐	anxiety	☐	☐	☐	poor awakening	☐	☐	☐	panic attacks
☐	☐	☐	ulcers	☐	☐	☐	low pain threshold	☐	☐	☐	_____

O	F	C		O	F	C		O	F	C	
☐	☐	☐	fevers	☐	☐	☐	fibromyalgia	☐	☐	☐	chronic fatigue
☐	☐	☐	multiple sclerosis	☐	☐	☐	depression	☐	☐	☐	auto-immune disorders
☐	☐	☐	epstein-barr syndr	☐	☐	☐	rheumatoid arthritis	☐	☐	☐	fatigue

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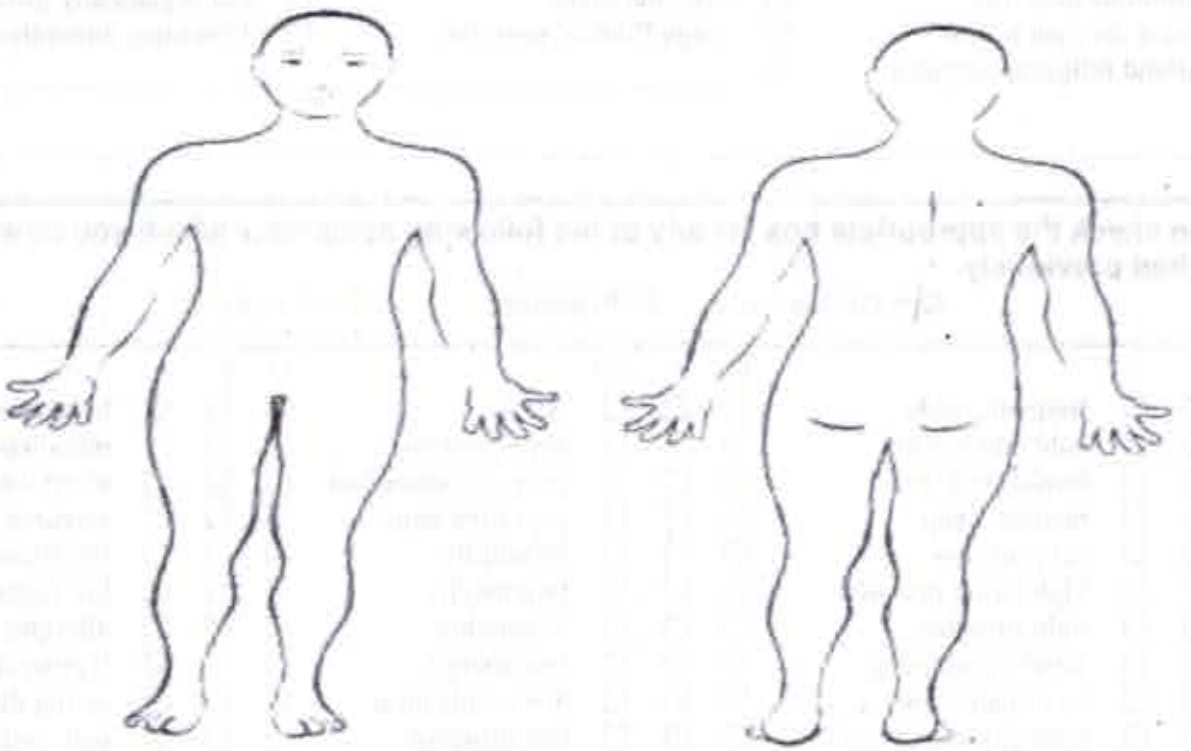

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O	F	C		O	F	C		O	F	C	
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