BALANCE FAMILY CHIROPRACTIC

Dr. Jennifer Murray
102-12840 Yonge Street, Oak Ridges, ON L4E-4H1 905.773.5165

Welcome to Balance Family Chiropractic. To help us serve you better, please provide us with the following information. Please note, there are 2 PAGES to this form!! We look forward to working with you.

Patient Name: _____
Date:_____ Gender: Male Female
Address: _____City: _____ Province____
Postal Code: _____ Home Phone: _____
Birth Date (day/month/year)___/___/___
E-mail_____
Who Referred You? _____
Names of Parents/Guardians_____

Purpose For Contacting Us? _____

Please circle any of the following conditions you have suffered from during the past six months:

Ear Infections	Scoliosis	Seizures	Chronic Colds
Asthma	Digestive Problems	ADHD	Recurring Fevers
Allergies	Bed Wetting	Car Accident	Headaches
Autism	Growing Pains	Back Pain	Other

Does condition interfere with:
Sleeping? yes no Daily Activities? yes no Exercising? yes no

When did you first notice this condition? _____

Were you ever knocked unconscious? Yes No Comments: _____

Have you ever broken any bones? Yes No Comments: _____

Previous Chiropractic Experience? Yes No Name of Chiropractor: _____
Date of last visit: ___/___/___
Name of Family Doctor: _____Date of last visit: ___/___/___
Reason:_____

Number of Doses of Antibiotics taken: During the past six months: _____
Total during lifetime: _____

Number of Doses and type of Other Prescription Medications taken:
During the past six months: _____
Total during lifetime: _____
Vaccination History:_____

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PATIENT NAME: _____

Are you involved in any high impact or contact sports (ie. Soccer, Football, Gymnastics, Baseball, Ballet, Martial Arts, etc) Yes No List: _____

Have you ever been involved in a car accident? No Yes List:_____
Have you ever been seen on an emergency basis? No Yes List: _____
Have you ever been hospitalized? No Yes List: _____
What was actually done to you? _____

Other traumas (falls, accidents, injuries) not described above? No Yes
List: _____

Prior Surgery? No Yes List: _____

Birth History
Complications during pregnancy? No Yes List: _____

Medications during pregnancy/delivery? No Yes List: _____

Birth Intervention: Forceps ___ Vacuum Extraction ___ Caesarian Section ___ Emergency/Planned___
Complications During Delivery? No Yes List: _____

Genetic Disorders or Disabilities? No Yes List: _____

Have you had: a spinal tap___spinal injections___ physiotherapy___
Neck collar___ spinal brace___ heel lift___ corrective shoes ___
bone in a case or immobilized___ naturopathy___ homeopathy___

Have you ever had X-rays done before? No Yes When? _____

I hereby authorize Dr. Jennifer Murray or her designate to perform a full and comprehensive examination my Son/Daughter which may include a case history, thermal scan, postural assessment and/or hands on Chiropractic examination. I clearly understand and agree that I am personally responsible for payment of all fees charged by Balance Family Chiropractic. I understand that my personal information will be kept confidential in accordance with the privacy legislation.

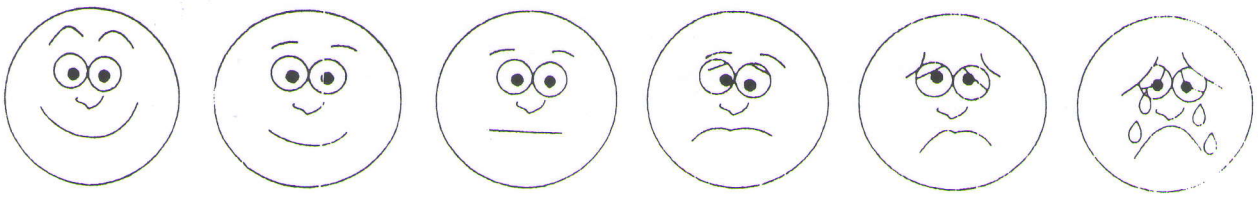
_____ _____
Parent Signature Date

_____ _____
Witness Signature Date

Faces and Visual Analog Pain Scales

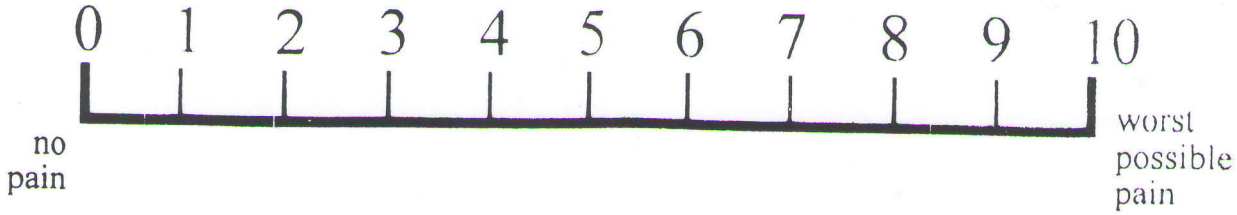
Please circle the number and/or the face that best refers to your level of pain (or lack thereof!) today. Please sign and date.

Faces Pain Scale



0	2	4	6	8	10
Very happy, no hurt	Hurts just a little bit	Hurts a little more	Hurts even more	Hurts a whole lot	Hurts as much as you can imagine (don't have to be crying to feel this much pain)

Visual Analog Scale (VAS)



Date: _____

Signature: _____