

Welcome to Pure. Please complete the following forms. Information collected is used to determine care required based on your current condition. After you are finished filling out these forms, you will meet with one of our highly trained staff members, who will review your history with you. Based on your history, certain examinations will be performed, including spinal images if necessary. Your case will then be reviewed by our team of practitioners and one of them will review your exam findings with you.

Please be prepared to	spend about 60 minutes with us today.						
	CONFIDENTIAL PATIENT HISTORY						
Name	Date: Postal Code 						
Address	City Postal Code						
Home Phone	Business Phone Cellular/Other						
Date of Birth	Email* SexMF Age Name and Ages of Siblings ChiropractorMassage TherapistPhysiotherapistNutritionist						
Number of Siblings	Name and Ages of Siblings						
Have you ever been to:	ChiropractorMassage TherapistPhysiotherapistNutritionist						
It yes to any ot the	e above, what clinic?						
How did you hear about Pu	re?						
Name of Family Medical D	octor Alberta Health Care Number remail appointment reminders and office communication pertaining to your care.						
*Your email will be used for	remail appointment reminders and office communication pertaining to your care.						
	PATIENT HEALTH STRESSORS						
There are many lifestyle stre	ssors that can effect your health. Please answer the following questions regarding lifestyle stressors.						
There are many mestyle site							
	STRESS LEVELS						
	Are there smokers in your home? Y N Is there stress in your child's life? Y N						
	Is there stress in your child's life? Y N						
	How many hours of sleep does your child get nightly?						
What do you perceive to be your child's greatest stressor?							
	NERVE SUPPLY						
	Is your child lethargic? Y N						
	Does your child have too much energy? Y N						
	Does your child have trouble staying focused? Y						
	Does your child have too much energy? Y N Does your child have trouble staying focused? Y N Any previous history of concussions? Y N						
	Does your child have poor posture? Y N						
	PRACTITIONER NOTES:						
	FUEL AND OXYGEN						
	Does your child have digestive issues? Y N						
	Do you have any breathing problems? Y N						
	Do you use supplements? Y N						
	What did your child eat for breakfast today?						
A Constant	What is your child's favourite vegetable?						
	PRACTITIONER NOTES:						
	MOVEMENT						
	Does your child engage in physical activities?						
	Would you consider your child flexible? Y N						
	Does your child have balance and or coordination issues? YN						
	How long does your child spend on physical activity each day outside of work?						
	PRACTITIONER NOTES:						

ABOUT YOUR HEALTH

Please check the appropriate boxes for symptoms that you have experienced:										
× 000000000	Backache Neck pain Painful tailbone Foot trouble Shoulder pain Herniated disc Spinal curvature Faulty posture Arthritis	000	PIRATORY Spitting up phlegm/blood Chest pain Difficulty breathing NARY Painful urination Urinating at night Blood in urine Increased urination		RADIOVASULAR Rapid heart beat Slow heart beat High blood pressure Low blood pressure Pain over heart Swelling of ankles Previous heart attack Poor circulation	000000	Deafness Earache Sore throat Asthma Tonsillitis Sinus trouble MALES ONLY Painful menstruation Excessive flow	PAS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	THEALTH Thyroid troubles Diabetes Tuberculous Emotional problems Epileptic seizures Asthma Artritis Alcoholism Polio Cancer	
STRI 0 0 0 0 0	Headaches/Migraines Dizziness Numbness Ringing in ears Blurring of vision Loss of sleep	GAS	Difficult digestion Belching or gas Nausea or vomiting Pain over stomach Constipation Colon trouble	GENERAL O Fever/chills/sweat O Fainting O Convulsions O Skin problems O Colds	00000	Irregular cycle Cramps or backache Abnormal discharge Past menopause Birth control pill	00	Venereal disease HIV DICATIONS:		
00000	Loss of concentration Irritable/Nervousness Depression Decreased Energy/fatigue Tension	000	Liver trouble Gall bladder trouble Heartburn Diarrhea Bloody stools	000	Tremors Loss of balance Allergies:	_		AC	CIDENTS/SURGERIES	
FAA 0 0 0	MILY HEALTH HISTORY Heart disease Diabetes Cancer Fatigue	0000	Asthma High blood pressure Low blood pressure Thyroid	0000	Arthritis Low back pain Anxiety Scoliosis					
			PATIENT H	IEA	LTH HISTORY			PR/	ACTITIONER NOTES:	
W	hat is your child's major	sym	ptom?					_		
	When was the first time you noticed this problem?									
How did it originally occur? Has it become worse recently?YesNoSameBetter Gradually										
If yes, when and how?										
How frequent is the condition?ConstantDailyIntermittentNightly										
Do they have any other conditions or symptoms that may be related to your major symptom?YesNo										
۸۰	If yes,	o alt	h problems?Yes		No					
	If ves.		·							
De	escribe the pain:Shar	ρ.	DullNumbness	_	Tingling Aching	B	Burning Stabbing			
ls	Other: there anything you can d	lo to	relieve the problem?	Yes	No If yes, how	Š				
					LayingBending					
W	hat makes the problem v Other:			ng	LayingBending	_	LittingTwisting	_		
Н	ave you had any broken	bon	es?YesNo							
Н	If yes, list with da	tes:		not i	ndicated on this form eith	er in	the past or the present?			
1 10					ndicaled on mis form cim					
	SYMP	ΤΟ/	M SCALE (please dr	aw	a line on the followin	g sc	cale)]=		
NO	SYMPTOMS	_		_			EXTREME SYMPTOMS	_		
					CONSENT TO CARE					
Ц І,			consent to receivi		ehabilitation services, and		a consultation, an examin	natio	on and x-rays, (if	
	cessary) to determine if I	am	a candidate for care at	PÜR	E.					
Services may include: heat therapy, muscular stimulation, acupuncture, joint/spinal mobilization/manipulation, myofascial release, interferential, gait analysis, and exercise prescription.										
I understand that health practitioners within PURE may share my health information between them in order to give me the highest level of care. I										
understand that all information shared between practitioners will remain completely confidential within PURE.										
Cl	nild's Name:					Do	ıte:			
Po	rent/Legal Guardian's S	igna	ture :			Wi	tnessed:			