

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 _ Address _ _ Postal Code ___ Home Phone __ ____ Cellular/Other ___ Business Phone _ Date of Birth _ _____ Sex ___M ___F Age ___ _Email* _ Occupation or Professions _____ _____ Employer __ Marital Status ___Single ___Married ___Divorced ___Common-Law Name of Spouse __ Number of Children _____ ___ Name and Ages of Children _ Have you ever been to: ___Chiropractor ___Massage Therapist ___Physiotherapist ___Nutritionist If yes to any of the above, what clinic? _ Is this complaint a result of a work related injury? How did you hear about Pure? _ Name of Family Medical Doctor _ __ Alberta Health Care Number ___ *Your email will be used for email appointment reminders and office communication pertaining to your care. PATIENT HEALTH STRESSORS There are many lifestyle stressors that can effect your health. Please answer the following questions regarding lifestyle stressors. STRESS LEVELS Do you smoke? Ν Is what you do for work stressful? How many hours of sleep do you get nightly? _ What do you perceive to be your greatest stressor? PRACTITIONER NOTES: **NERVE SUPPLY** Would you like more energy? Ν Do you have trouble staying focused? Ν Any previous history of concussions? Ν Does you have poor posture? Ν PRACTITIONER NOTES: **FUEL AND OXYGEN** Does you have digestive issues? Ν Do you have any breathing problems? Ν Υ Do you use supplements? Υ Ν Do you drink coffee or alcohol? Ν What did you eat for breakfast today? PRACTITIONER NOTES: MOVEMENT Does you have a fitness club membership that you use? Ν Would you consider yourself flexible? Ν Could you run 5km without stopping? How long do you 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	Spitting up phlegm/blood Chest pain Difficulty breathing INARY Painful urination Urinating at night Blood in urine Increased urination	000000000	RDIOVASULAR Rapid heart beat Slow heart beat High blood pressure Low blood pressure Pain over heart Swelling of ankles Previous heart attack Poor circulation Previous stroke Heart Disease	000000	Deafness Earache Sore throat Asthma Tonsillitis Sinus trouble MALES ONLY Painful menstruation Excessive flow	000000000	THEALTH Thyroid troubles Diabetes Tuberculous Emotional problems Epileptic seizures Asthma Artritis Alcoholism Polio
STR O O O O O O O O	Headaches/Migraines Dizziness Numbness Ringing in ears Blurring of vision Loss of sleep Loss of concentration Irritable/Nervousness Depression	GA: 000000000	Difficult digestion Belching or gas Nausea or vomiting Pain over stomach Constipation Colon trouble Liver trouble Gall bladder trouble Heartburn	O GEN O O O O O O O	NERAL Fever/chills/sweat Fainting Convulsions Skin problems Colds Tremors Loss of balance Allergies:	0 0 0 0	Irregular cycle Cramps or backache Abnormal discharge	000 ME	Cancer Venereal disease HIV DICATIONS:
0	Decreased Energy/fatigue	Ō	Diarrhea	_	- morgios.	Dυ	e Date:	AC	CIDENTS/SURGERIES
0	Tension	0	Bloody stools			Pre	vious no. of miscarriages:	_	
FA/ 0 0 0	MLY HEALTH HISTORY Heart disease Diabetes Cancer Fatigue	0000	Asthma High blood pressure Low blood pressure Thyroid	0000	Arthritis Low back pain Anxiety Scoliosis				
PATIENT HEALTH HISTORY PRACTITIONER NOTES:									
What is your major symptom? When was the first time you noticed this problem? How did it originally occur? Has it become worse recently?YesNoSameBetterGradually									
NO SYMPTOMS EXTREME SYMPTOMS									
I, consent to receiving rehabilitation services, and/or a consultation, an examination and x-rays, (if									
necessary) to determine if I am a candidate for care at PURE. 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.									
Si	Signature:								
Pr	int Name :					W	itnessed:		