Dr. Shannon R. Asbury
73 Sherwood Glen
Holland Landing, Ontario L9N 1R3
(905) 853-8565

Name_____M____F____Birthdate_____

Address _____

_____Postal Code_____

Home Phone_____Business Phone_____X_____

E-mail_____Occupation_____

Emergency Contact_____Relation_____Phone_____

If patient is under 18 years of age:

Name of Mother_____Name of Father_____

Have you received chiropractic care previously? Yes_____No_____

If yes, Name of Practitioner_____Location_____

Date of last appointment_____Reason for appointment_____

Are you under the care of another healthcare practitioner? Yes_____No_____

If yes, Name of Practitioner_____Location_____

Date of last appointment_____Reason for appointment_____

Date of last physical_____

Reason for consulting Dr. Asbury_____

Other doctors seen for this condition_____

Types of treatment_____

Results_____

Patient_____Date_____

If you are a female:

Number of pregnancies_____

Number of live births_____

Number of miscarriages_____

Number of abortions_____

Are you currently pregnant? Yes_____No_____Not Sure_____

If yes, what is your due date?_____

When was your last period?_____

For all patients:

Have you had x-rays taken in the last 3 years? Yes_____No_____

If yes, please list areas_____

Do you suffer from allergies? Yes_____No_____

If yes, please specify_____

Do you exercise regularly? Yes_____No_____If yes, how often?_____

Do you have regular sleep habits? Yes_____No_____How many hours/night?_____

Do you snore? Yes_____No_____

Do you wake feeling refreshed? Yes_____No_____

Rate the level of negative stress in your life:

Very Low_____Low_____Moderate_____High_____Extreme_____

How much water do you drink a day?_____

What kind of water do you drink? Tap_____Filtered_____Spring_____Reverse Osmosis_____

What medications are you currently taking? (Please give name and dosage)

_____ _____

_____ _____

_____ _____

What supplements (vitamins/minerals/herbs/homeopathic remedies/other) are you currently taking?

_____ _____

_____ _____

_____ _____

Patient_____Date_____

Which of the following do you currently use? (Please indicate how much and how often)

Alcohol_____ Tobacco_____

Hormones_____ Coffee_____

Sedatives_____ Tea_____

Antacids_____ Soda_____

Laxatives_____ Recreational Drugs_____

Past Health Condition

Please indicate the occurrence of the following and give details and dates:

Surgeries_____

_____

Major Injuries_____

_____

Loss of Consciousness_____

_____

Hospitalization_____

_____

Major Illnesses_____

_____

Seizures_____

_____

Vaccinations_____

_____

Significant Life-Changing Events_____

_____

Patient_____Date_____

Please indicate which of the following conditions you have had "Now"(N) or in the "Past" (P)

Generals
Allergies
Fatigue
Frequent Headaches
Dizziness
Fainting
Anemia
Cold/Tingling Extremities
Loss of Sleep
Nervousness
Tremors
Convulsions
General Stiffness
Paralysis
Walking Problems
Osteoporosis

EENT
Vision Problems
Chronic Red Eyes
Hearing Difficulty
Ringing in Ears
Frequent Earaches
Chronic Stuffed Nose
Frequent Nose Bleeds
Frequent Colds/Flu
Chronic Sore Throat
Dental Problems
Speech Problems

Gastro-Intestinal
Poor/Excessive Appetite
Poor/Excessive Thirst
Stomach Problems
Frequent Heartburn
Gas/Bloating after Meals
Abdominal Cramping
Frequent Nausea
Frequent Vomiting
Frequent Diarrhea
Frequent Constipation
Colon Problems
Black/Bloody Stools
Liver Problems
Gallbladder Problems
Weight Problems

Respiratory
Asthma
Chronic Cough
Lung Problems
Breathing Difficulty

Cardio-Vascular
Chest Pain
Heart Problems
Irregular Heartbeat
Blood Pressure Problems
Hardening of Arteries
Varicose Veins
Poor Circulation
Bruise Easily
Aneurysm
Stroke

Genito-Urinary
Painful Urination
Excessive Urination
Freq/Infreq Urination
Constant Desire to Urinate
Loss of Urinary Control
Kidney Problems
Bladder Problems
Blood in Urine
Prostate Problems
Sexual Dysfunction

Pain or Numbness in
Shoulders
Arms
Hands
Hips
Legs
Knees
Ankles
Feet
Neck
Mid Back
Low Back
Tailbone
Head
Face
Jaw

Mind
Depression
Mental Disorders
Child Abuse
Physical Abuse
Sexual Abuse
Emotional Abuse
Rape

Diseases
Alcoholism
Cancer
Diabetes
Hepatitis
Scarlet Fever
Polio
Measles
Mumps
Chickenpox
Whooping Cough
Shingles
Diptheria
Rheumatic Fever
Smallpox
Tuberculosis
Malaria
Herpes
Mononucleosis
STD
HIV

For Women Only
Menstrual Irregularities
Heavy Cramping
Fibroids
Ovarian Cysts
PMS
Breast Pain/Lumps
Miscarriage
Sexual Dysfunction

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