Dr. Jeff Hedrich Chiropractic, Stimpod, Shockwave, Acupuncture and EMTT

204, 740 - 4 Avenue South, Lethbridge, AB T1J 0N9 403-381-2132

Please print and fill out completely. Use **BLACK INK** only

Date: D/M/YY	Gender:	Biological Sex:
Last Name:	First Name:	AHC #:
Address:	City/Town	Postal Code
Birthday: D/M/YY	Email Address (optional):	Occupation
Home Phone:	Business Phone:	Cell Phone:
Employer:	Business Address	
Marital Status:	Ages of children:	
Name of spouse:	Emergency contact Info:	
Responsible party: Guardian Self Parent	Who recommended this clinic to you?	Physician:

Please, answer each question even if you do not feel it is relevant

Previous Chiropractic Care: No Yes Chiropractor: City:

What were you treated for? Results? Xrays?

What/where is your major complaint?

What other care have you for this condition?

How long have you had this condition?

What caused this condition?

Is this condition a result of a recent motor vehicle accident? No Yes

Is this WCB? No Yes

Is this condition getting worse? No Yes

Is this condition causing other problems?

Is his condition interfering with your: Work Sleep Daily activity Other

What activities aggravate your condition?

What makes it feel better?

Have you had this or similar condition in the past? No Yes Dates:

What other health concerns do you have?

Are you taking: *Birth Control* *Muscle Relaxant* *Anti-depressants* *Pain Killers* *Blood Thinners*

Statins *Vitamins* *Antibiotics* *Heart Medication* *Antihistamines* *Anti-inflammatory*

Other medications including over-counter products?

Have you ever been in an auto accident? No Yes When?

Have you had any other personal injury? Past Year Past 5 Years Over 5 years None

Interests and hobbies: