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

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/YYYY	Gender:	
Last Name:	First Name:	AHC #:
Address:	City/Town	Postal Code
Birthday: D/M/YYYY	Email Address:	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? X-Rays? Yes No

What other care have you for this condition?

What/where is your major complaint?

How long have you had this condition?

What caused this condition?

Is this condition a result of an auto accident? No Yes (If yes and the accident is recent, please ask for accident forms)

Is this WCB? Yes No

Is this condition getting worse? Yes No

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 Nerve Pills Anti-depressants Pain Killers Insulin Blood Thinners Tranquilizers Vitamins Antibiotics Heart Medication Antihistamines Anti-inflammatory None*

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:

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- Appendicitis
- Scarlet Fever
- Diphtheria
- Typhoid fever
- Pneumonia
- Rheumatic Fever
- Polio
- Lupus
- Osteoporosis
- Malaria
- Tuberculosis
- Whooping Cough
- Anaemia
- Measles
- Mumps
- Small Pox
- Heart attack/stroke
- Fibromusculous dysplasia
- Chicken Pox
- Diabetes
- Cancer
- Heart Disease
- Influenza (flu)
- Multiple Sclerosis
- Auto Immune Disorder
- Homocysteinemia
- AIDS
- Alcoholism
- Food poisoning
- Arthritis
- Epilepsy
- Mental Disorder
- COVID-19
- Eczema/Psoriasis
- Hepatitis
- Ehlers Danlos syndrome

Please Circle: "C" - Current condition "P" - Past problems

MUSCULO-SKELETAL

C P Low/Mid Back pain
C P Pain Between the Shoulders
C P Neck Pain
C P Arm Pain
C P Knee Pain
C P Leg Pain
C P Difficulty Chewing/clicking
C P Arthritis

NERVOUS SYSTEM

C P Numbness
C P Paralysis
C P Dizziness
C P Forgetfulness/confusion
C P Convulsions
C P Cold/Tingling Extremities
C P Poor muscle control/tremors

GENERAL

C P Allergies Food/Seasonal
C P Loss of Sleep
C P Fever
C P Headaches
C P Fatigue
C P Anxiety/panic attacks
C P Depression

GENITO-URINARY

C P Bladder Troubles
C P Painful/excess Urination
C P Sweet Smell
C P Irregular Period
C P Erectile Dysfunction
C P Blood in Urine
C P Frequent Kidney Infections
C P Menstrual Pain

GASTRO-INTESTINAL

C P Poor/Excessive Appetite
C P Excessive Thirst
C P Frequent Nausea
C P Vomiting
C P Diarrhea
C P Constipation
C P Liver Trouble
C P Gall Bladder Problems
C P Weight Changes
C P Abdominal Cramps
C P Painful Eye
C P Gas/Bloating after Meals
C P Heartburn
C P Black/Bloody Stool
C P Colitis

C-V-R- CODE

C P Chest pain
C P Shortness of breath
C P Blood Pressure Problems
C P Irregular Heartbeat
C P Heart Problems
C P Lung Problems/Congestion
C P Asthma
C P Emphysema
C P Varicose Veins
C P Ankle Swelling
C P High Cholesterol

EENT CODE

C P Vision Problems
C P Dental Problems
C P Sore Throat
C P Ear Aches
C P Hearing Difficulty
C P Decreased Smell

FEMALES ONLY:

When was your last period?_____
Are you Pregnant? Yes No Maybe

IMMEDIATE FAMILY DISEASES

CIRCLE- to determine if hereditary

Epilepsy
Cancer
Allergies
Arthritis
Asthma
Multiple Sclerosis
Alcoholism
Stomach Ulcers
Heart Disease
Low Back Pain
Diabetes

SURGICAL

Y N Hip Replacement
Y N Knee Replacement
Y N Removal of Organs
Y N Organ Transplants
Y N Neck Surgery
Y N Thoracic Surgery
Y N Lower Back Surgery
Y N Shoulder Surgery
Y N Wrist Surgery
Y N Other Surgery
If "Y" Please specify:

Does the pain radiate anywhere?_____

Is there a family Hx of the problem?_____

Orthopaedic	L	R
1. Rotary Comp		
2. Lat Flx Comp		
3. Traction		
4. Shoulder Depr		
5. Cervical Kemps		
6. Allens Ce Wr		
7. Resisted Flex/Ext		
8. Edens		
9. Soto Hall		
10. Apleys Scratch		
11. Dawburns (bursa)		
12. Supraspinatus		
13. SLR		
14. Braggards		
15. Faejerstein		
16. Leg Lowering		
17. Valsalva		
18. Lumbar Kemps		
19. Thomas (opp psoas)		
20. FABER		
21. FADDIR		
22. Yeoman (SI)		
23. Iliac compression		
24. Sup'd Adams		
25. Trendelenburg		
26. Heel Walk		
27. Toe Walk		
28. Varus Stress		
29. Valgus Stress		
30. A or P Drawer Test		

(0-4) 2 is normal

Reflexes	L	R
Bra-rad		
Triceps		
Biceps		
Patellar		
Ham		
Achilles		

0K—Normal

1—Mild

2—Moderate

3—Severe

Loss of ROM	C	C	L	L
Flexion				
Extension				
Rt lat flexion				
Lt lat flexion				
Rt rotation				
Lt rotation				

Verbal consent to exam given ☐

Explanation of positive tests:

_____

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Pain Dermatome/Palpation:

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Additional Examinations:

Leg length_____ Head tilt_____

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Diagnosis:

Clinical Impressions:

Doctor's Signature: