

**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/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 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: <i>Birth Control Muscle Relaxant Nerve Pills Anti-depressants Pain Killers Insulin Blood Thinners</i>				
<i>Tranquilizers Vitamins Antibiotics Heart Medication Antihistamines Anti-inflammatory None</i>				
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    | - Malaria                  | - Chicken Pox          | - Alcoholism             |
| - Scarlet Fever   | - Tuberculosis             | - Diabetes             | - Food poisoning         |
| - Diphtheria      | - Whooping Cough           | - Cancer               | - Arthritis              |
| - Typhoid fever   | - Anaemia                  | - Heart Disease        | - Epilepsy               |
| - Pneumonia       | - Measles                  | - Influenza (flu)      | - Mental Disorder        |
| - Rheumatic Fever | - Mumps                    | - Multiple Sclerosis   | - COVID-19               |
| - Polio           | - Small Pox                | - Auto Immune Disorder | - Eczema/Psoriasis       |
| - Lupus           | - Heart attack/stroke      | - Homocysteinemia      | - Hepatitis              |
| - Osteoporosis    | - Fibromusculous dysplasia | - AIDS                 | - 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           | Alcoholism     |
| Cancer             | Stomach Ulcers |
| Allergies          | Heart Disease  |
| Arthritis          | Low Back Pain  |
| Asthma             | Diabetes       |
| Multiple Sclerosis |                |

**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 Kemp's		
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 Kemp's		
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
	Pre	Post	Pre	Post
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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Diagnosis: \_\_\_\_\_

Clinical Impressions: \_\_\_\_\_

Doctor's Signature: \_\_\_\_\_