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:	Biological Sex:
Last Name:	First Name:	AHC #:
Address:	City/Town	Postal Code
Birthday: D/M/YYYY	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:	Who recommended this clinic to you?	Physician:
Self Parent		

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? 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 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 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: