



Dr. Jabeen Jussa, B.Sc., D.C.
DOCTOR OF CHIROPRACTIC

MAINTAIN. RESTORE. ENHANCE

Thank you for choosing our clinic for your Chiropractic Needs. Please complete this form. If you have any questions, please feel free to ask.

Date: _____

PATIENT INFORMATION:

NAME _____ DATE OF BIRTH (M/D/Y) _____

ADDRESS _____

CITY _____ PROVINCE _____ POSTAL CODE _____

PHONE # Home _____ Mobile _____ Work _____

EMAIL ADDRESS _____ OCCUPATION _____

MEDICAL DOCTOR NAME _____ PHONE # _____

CARE CARD # _____

HOW DID YOU HEAR ABOUT OUR CLINIC?

- () Internet () Building Signage () Phone book () Brochure
- () Friend _____ () Work Colleague _____
- () Medical Doctor _____ () Family Member _____
- () Massage Therapist _____ () Physiotherapist _____
- () Other _____

Do you have extended health care insurance? Yes No If yes, with whom? _____

Have you received Chiropractic Care previously? Yes No

Reason for past Chiropractic Care _____

Results: Excellent Good Fair Poor

ARE YOU CLAIMING:

Worker Compensation Board	Yes	No	Claim # _____	Adjustors Name: _____
I.C.B.C	Yes	No	Claim # _____	Adjustors Name: _____

OTHER HEALTH CARE PRACTITIONERS TREATING YOU?

- () Massage Therapy () Acupuncture () Physiotherapy () Naturopathic Doctor
- () Other : _____



Dr. Jabeen Jussa, B.Sc., D.C.
DOCTOR OF CHIROPRACTIC

MAINTAIN. RESTORE. ENHANCE

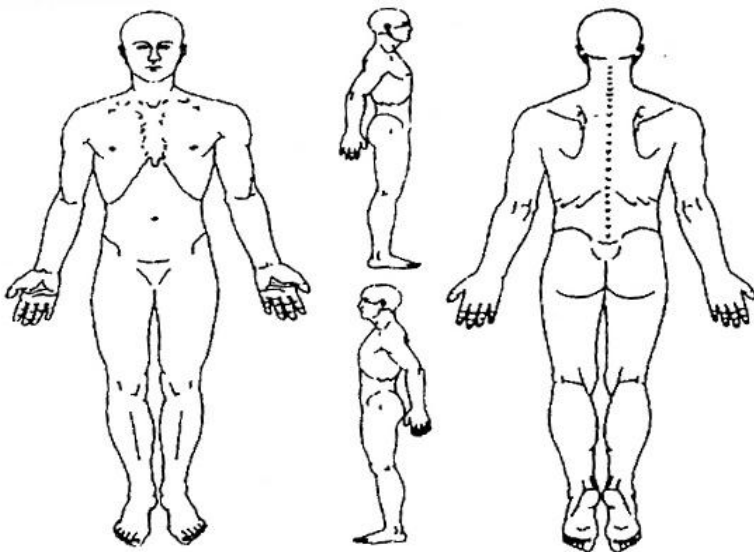
REASON FOR TODAY'S VISIT:

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

- A** = Ache
- B** = Burning
- N** = Numbness
- O** = Other
- P** = Pins & Needles
- S** = Stabbing

Are your symptoms changing?

- Improving
- Not Changing
- Getting Worse



Have you undergone any surgeries? Yes No If yes, briefly describe

Have you ever had any falls, injuries, car accident, traumas, head injuries, accidents? Yes No
Describe

Are you currently taking any medications (prescription or over the counter) Yes No

List: _____

Are you currently taking any vitamins, minerals or herbal supplements Yes No

List: _____



Dr. Jabeen Jussa, B.Sc., D.C.
DOCTOR OF CHIROPRACTIC

MAINTAIN. RESTORE. ENHANCE

Do you currently wear Custom – made Orthotics? Yes No If yes, how old are they? _____

When was your last physical exam? _____

For Women:

Menstrual Problems: Yes No If yes, describe _____

Are you pregnant: Yes No If yes, expected due date _____

Please mark with an “√” if you are currently experiencing or have experienced any of the following:

- | | | |
|--------------------------------------------------|-------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> headaches | <input type="checkbox"/> general fatigue | <input type="checkbox"/> sciatica |
| <input type="checkbox"/> neck pain | <input type="checkbox"/> depression | <input type="checkbox"/> hay fever |
| <input type="checkbox"/> jaw pain | <input type="checkbox"/> slipped disc | <input type="checkbox"/> migraines |
| <input type="checkbox"/> pain between shoulders | <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> neck spasms |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> anemia | <input type="checkbox"/> loss of weight |
| <input type="checkbox"/> sinusitis | <input type="checkbox"/> visual problems | <input type="checkbox"/> night sweats |
| <input type="checkbox"/> stroke | <input type="checkbox"/> ear infections | <input type="checkbox"/> clicking in neck |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> cold hands/feet | <input type="checkbox"/> liver trouble |
| <input type="checkbox"/> nausea | <input type="checkbox"/> stomach pain | <input type="checkbox"/> excessive gas |
| <input type="checkbox"/> loss of vision | <input type="checkbox"/> heart burn/indigestion | <input type="checkbox"/> gall bladder stones |
| <input type="checkbox"/> loss of taste/smell | <input type="checkbox"/> loss of memory | <input type="checkbox"/> painful urination |
| <input type="checkbox"/> fainting spells | <input type="checkbox"/> bladder infections | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> loss of consciousness | <input type="checkbox"/> ulcers | <input type="checkbox"/> aortic aneurysm |
| <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> prostate problems | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> blood disorders | <input type="checkbox"/> constipation |
| <input type="checkbox"/> allergies | <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney problems |
| <input type="checkbox"/> asthma | <input type="checkbox"/> cancer | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> heart attacks |
| <input type="checkbox"/> pinched nerve | <input type="checkbox"/> Thyroid Problems | |