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

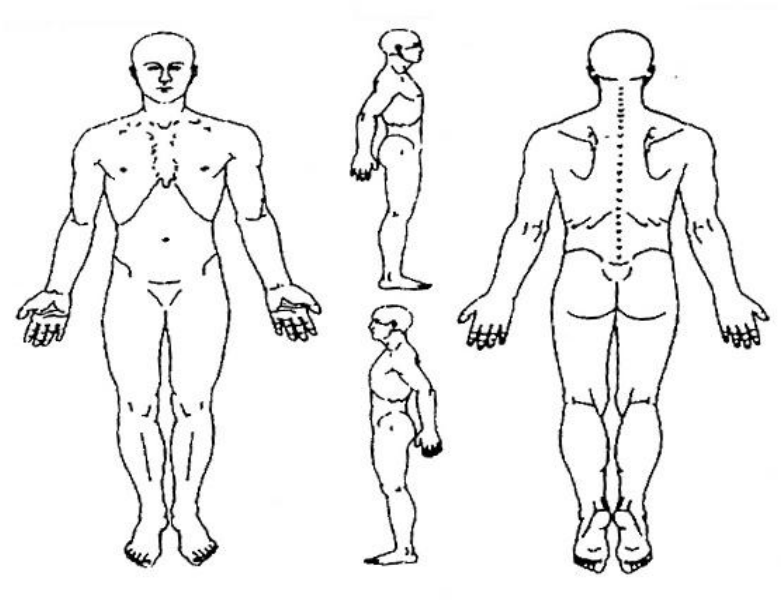
MAINTAIN. RESTORE. ENHANCE

REASON FOR TODAYS 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:

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