

**DR. BRENT SOUTER, B.A., D.C.**

C H I R O P R A C T O R

# PATIENT INFORMATION

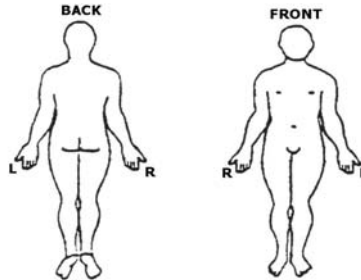
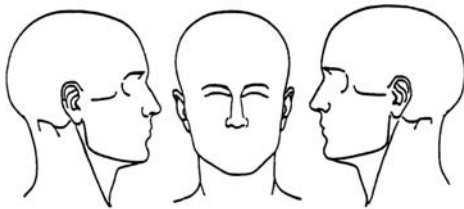
Patient Name \_\_\_\_\_ Date \_\_\_\_\_  
 Age \_\_\_\_\_ Date of Birth(dd/mm/yyyy) \_\_\_\_\_ Sex M / F  
 Occupation \_\_\_\_\_ Ontario Health Card # \_\_\_\_\_ Version Code \_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_ Postal Code \_\_\_\_\_  
 Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_  
 How did you hear about our office ? \_\_\_Walk-in \_\_\_Phone Book \_\_\_Advertising  
 \_\_\_Referral \_\_\_\_\_ Name of family medical doctor \_\_\_\_\_  
 Address \_\_\_\_\_

Prior Chiropractic Care? \_\_\_YES \_\_\_NO Prior X-RAYS \_\_\_YES \_\_\_NO

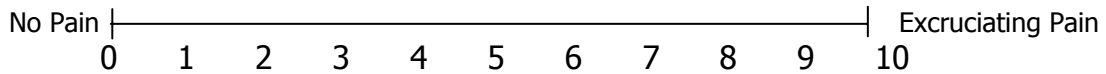
Please describe your present symptoms \_\_\_\_\_

Use the following descriptive symbols on the body outlines below to describe the location of your complaint(s).

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
AAA	BBB	OOO	.....	////	XXXXX



Please indicate the intensity of the pain described above by marking the following lines:



Indicate which of the following activities make your symptoms - Better or Worse

- ( ) B ( ) W Sitting      ( ) B ( ) W Bending Forward      ( ) B ( ) W Movement/Activity  
 ( ) B ( ) W Standing      ( ) B ( ) W Inactivity      ( ) B ( ) W Laying Down

Describe how and when your present symptoms started:

How: \_\_\_Gradual Onset \_\_\_Work Injury \_\_\_Motor Vehicle Accident \_\_\_Other \_\_\_\_\_

When: \_\_\_\_\_

Is your condition: improving\_\_\_\_ worsening\_\_\_\_ constant\_\_\_\_ intermittent\_\_\_\_

