Dr. Graham Kucan, BSc., DC.

Chiropractor
CCO #5008

Kucan Chiropractic & Acupuncture Clinic

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Please take the time to fill out this questionnaire carefully. The information you provide will assist me in formulating a complete health profile and diagnosis for you. All of your answers are absolutely confidential. If you have any questions, please ask. If you need more room, please use the other side of these sheets. Thank you.

Name: ____ Date: __________________

Date of Birth: _____________________ Age: _____ Gender: _____ Marital Status: _______

Address: ____

Town/City: _____________________ Province: ______ Postal Code: __________________

Email Address: ____

Home Phone: _________________________ Cell Phone: ______________________________

Work Phone: _________________________ Occupation: ______________________________

Is it OK to leave a message at home? YES/NO On your cell? YES/NO At work? YES/NO

Referred by: _________________________ Physician: ______________________________

Emergency Contact: _______________________________ Phone: ______________________

Have you had any imaging done? Please include as much information as possible (ie. Dates, location)
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Have you ever seen a Chiropractor before? YES/NO

If yes, please tell me what the experience was like.
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MAIN COMPLAINT (Symptoms? Diagnosis? When and how did it start?)

What makes your condition BETTER? (Rest, movement, heat, cold, medication, etc.)

What makes your condition WORSE? (Stress, position, activity, heat, cold, foods, weather, time of day/month, etc.)

What other interventions have you tried? (Doctors, tests, therapies, medications, supplements, etc?)

YOUR MEDICAL HISTORY:

Accidents or Traumas (Falls, accidents, car accidents, work injuries, sports injuries, etc.)

Surgeries (Please include dates)

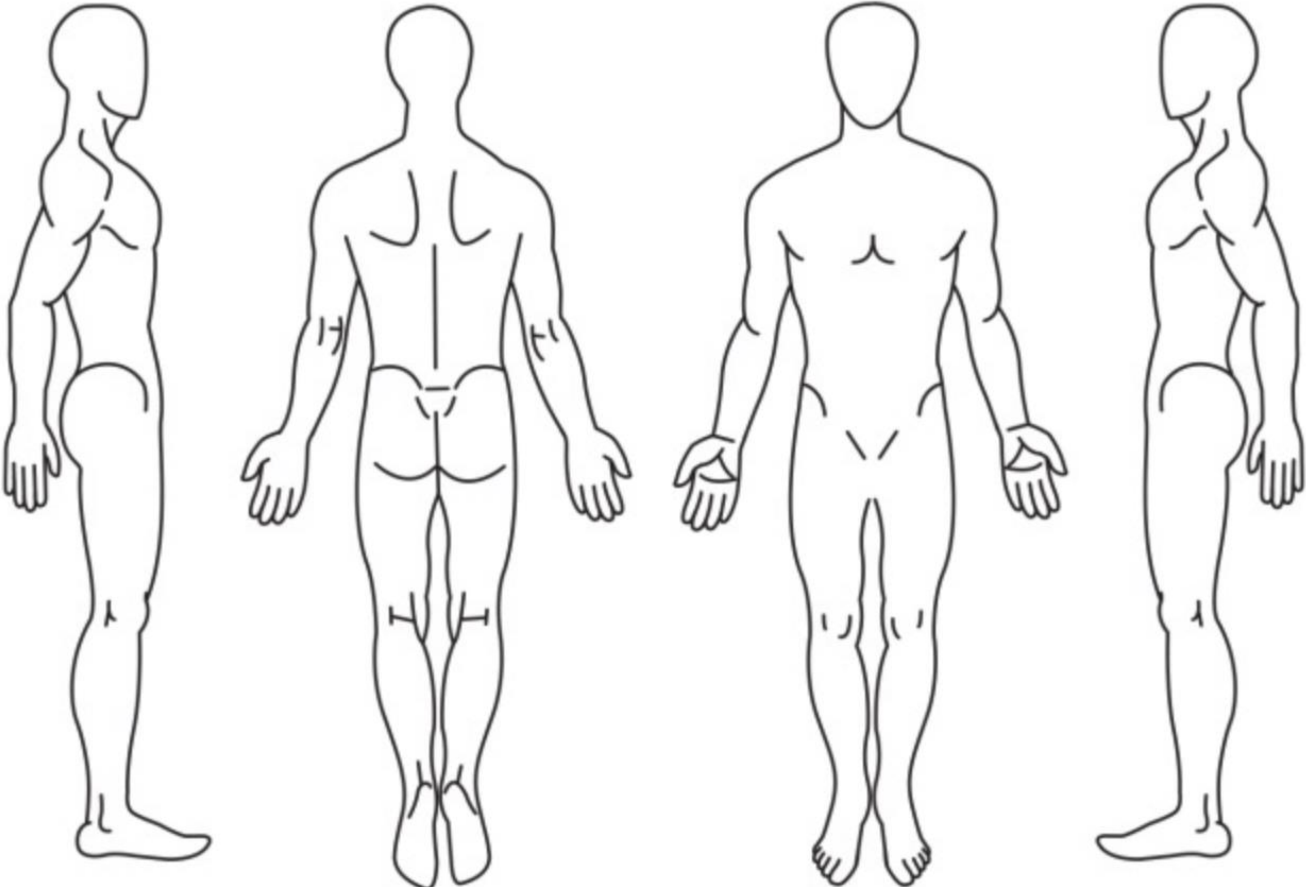
Surgeries recommended but not performed

Medications (including names & dosages; please attach an additional page if necessary)

Vitamins/Supplements/Herbs (please attach an additional page if necessary)

Using the appropriate symbols, please indicate all areas of pain, unusual feelings or discomfort.

Ache	Burning	Numbness	Pins/Needles	Stabbing	Other
AAAA	BBBB	NNNN	PPPP	SSSS	OOOO



PERSONAL HEALTH HISTORY (Please check any condition or symptoms that YOU HAVE NOW, OR HAVE EVER HAD IN THE PAST)

- Addiction
- AIDS/HIV
- Anemia
- Appendicitis
- Arthritis
- Asthma
- Autoimmune disease
- Birth trauma (your own birth)
- Bleeding disorder
- Cancer
- Chicken pox
- Chronic fatigue
- Chronic pain
- Crohn's/Colitis
- Diabetes
- Diverticulitis
- Epilepsy
- Food allergies/intolerances
- Fracture
- Gastritis/pancreatitis
- Heart attack
- Heart disease
- Hepatitis
- Herpes
- High blood pressure
- High cholesterol
- Hyperglycemia
- Hyperthyroid
- Hypoglycemia
- Hypothyroid
- Irritable bowel syndrome
- Kidney disease
- Liver/gallbladder disease
- Low blood pressure
- Low blood sugar
- Lung disease
- Lyme disease
- Measles
- Multiple sclerosis
- Mumps
- Osteoarthritis
- Pacemaker
- Polio
- Rheumatoid Arthritis
- Seizure
- Stroke
- Tuberculosis
- Ulcers
- Other ___________________

EXERCISE

Days per week? ____________ Types of activities? ______________________ Length of workout? ____________

LIFESTYLE

Meals per day? _______________ Snacks? ________________ Caffeine? ________________ Water? _________________

Alcohol per week? _____________ Smoking/Vaping? _______________ Recreational drugs? _________________

FAMILY MEDICAL HISTORY (Please check any condition THAT APPLIES TO YOUR IMMEDIATE FAMILY. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), or GF (grandfather) in the blank.)

- Addiction _______
- Allergies _______
- Asthma _______
- Cancer _______
- Diabetes _______
- Heart disease _______
- High blood pressure _______
- Thyroid disorder _______
- Seizures _______
- Stroke _______
- Other _______________________
  ____

Please CHECK if you have had any of the following symptoms IN THE LAST YEAR.
Please CIRCLE if you have had any of the following symptoms IN THE PAST, BUT DON'T ANY LONGER.

GENERAL

- Poor appetite
- Insomnia/poor sleep
- Shift work
- Fatigue
- Dizziness
- Sudden energy drop
- Weakness
- Heaviness
- Chills/Cold
- Feverishness/Heat
- Night sweats
- Nausea
- Sweats for no apparent reason
- Tremors/tics
- Poor balance/frequent falls
- Bleed/bruise easily
- Weight loss
- Weight gain

SKIN AND HAIR

- Rash
- Itching
- Dryness
- Eczema/psoriasis
- Hair Loss
- Recent moles
- Ulcerations
- Hives/Allergic Dermatitis
- Warts
- Weak/ridged nails

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HEAD, EYES, EARS, NOSE AND THROAT

- Eye strain/pain
- Eye redness/itching/dryness
- Poor/blurry vision
- Glasses
- Night blindness
- Color blindness
- Floaters
- Cataracts
- Glaucoma
- Headaches
- Migraines
- Dizziness
- Vertigo
- Ringing in ears
- Earaches
- Poor hearing
- Facial pain/pressure
- Sinus problems
- Environmental allergies
- Post-nasal drip
- Nose bleeds
- Jaw pain/clicks/locks
- Grinding/clenching teeth
- Dental/gum problems
- Dry mouth
- Peculiar tastes/smells
- Sores on lips/tongue
- Recurrent sore throat/colds
- Difficulty swallowing

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RESPIRATORY

- Cough/wheezing
- Asthma
- Bronchitis
- Pneumonia
- COPD
- Emphysema
- Pain with deep inhalation
- Tight sensation in chest
- Coughing up blood
- Difficulty inhaling/ exhaling
- Difficulty breathing when laying down
- Difficulty breathing with exertion

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CARDIOVASCULAR

- Chest pain
- Chest pressure
- Irregular heart beat
- Palpitations at rest
- Fainting
- Cold hands/feet
- Swelling of hands/feet
- Shortness of breath
- Blood clots
- Varicose/Spider veins
- Phlebitis

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GASTROINTESTINAL

- Burping or gas
- Constipation
- Diarrhea
- Stomach pain
- Vomiting
- GERD/acid reflux
- Food intolerances ______ ______________________________
- Hiatal hernia
- Bloating/edema
- Abdominal pain/cramping

GENITO-URINARY

- Frequent urination
- Urgent urination
- Unable to hold urine
- Pain on urination
- Burning on urination
- Cloudy urine
- Difficulty forming stream
- Dribbling after urination
- Urinary tract infection
- Night urination… What time?__________ How often?______________

FOR WOMEN ONLY

- Back pain with cycle
- Menopausal
- Last menstruation date? ______________________
- Pregnant ? ________________________

MUSCULOSKELETAL

- Arm/ elbow pain
- Bursitis
- Carpal tunnel syndrome
- Degenerative Disc Disease
- Dislocated joints
- Foot/ ankle pain
- Hand/ wrist pain
- Hip pain
- Knee pain
- Leg pain
- Lower back pain
- Mid back pain
- Muscle pain
- Muscle weakness/fatigue
- Muscle spasms
- Muscle stiffness
- Neck pain
- Numbness in arms/ hands
- Numbness in legs/ feet
- Osteoporosis/ Osteopenia
- Rotator cuff/ shoulder pain
- Sciatica
- Scoliosis
- Sprains/strains
- Tendonitis/ Tendinosis

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NEUROPSYCHOLOGICAL

- Nerve pain
- Numbness
- Seizures
- Poor balance/falling
- Lack of coordination
- Poor memory
- Difficulty concentrating
- Concussion
- Depression
- Nervousness
- Anxiety/panic attacks
- Restless/jittery
- Difficulty sleeping
- Bad temper/irritable
- Easily susceptible to stress
- Seasonal Affective Disorder
- ADD/ADHD
- Bipolar disorder
- OCD
- PTSD
- Other ______________________

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COMMENTS

Please inform me of any other issues you would like to discuss.

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