P.2 - OPENING FILE [04/12/2011] , DOB: / /

#1 Father : age ☐ If deceased, cause ______

#2 Mother : age ☐ If deceased, cause ______

#3 Do you have brothers or sisters ○ Yes ○ No

#4 Do members of your family have : ☐ Cardiac problems ☐ Cancer ☐ Diabetes ☐ Arthritis ☐ Others ______

#5 Are you taking any medication at this time?

- ☐ No
- ☐ Anti-inflammatory
- ☐ Pain killers
- ☐ Muscular relaxants
- ☐ Non-prescribed medicines
- ☐ Hormones
- ☐ High blood pressure
- ☐ Diabetes
- ☐ For the thyroid gland
- ☐ ' The pill '

#6 What is your work position?

☐ Standing ☐ Sitting ☐ Moving

#7 Do you wear ... ?

☐ A heel lift ☐ Shoe orthotics

#8 Do you usually sleep on your ...?

☐ back ☐ side ☐ stomach

#9 How many hours do you sleep at night?

☐ [4h and less] ☐ [5h - 6h] ☐ [7h - 8h]
☐ [9h -10h] ☐ [10h - 11h] ☐ [12h and more]

#10 Do you consume ... ? If yes, how many?

tobacco/cigarettes	☐ Yes ☐ No	
alcohol	☐ Yes ☐ No	
coffee/tea	☐ Yes ☐ No	
Do you take vitamins or supplements?	☐ Yes ☐ No	

Do you exercise?

☐ Yes ☐ No

Have you had or do you have any of the following problems?

Allergies	High blood pressure	Hearing problems
Anxiety	Hypoglycemia	Hormonal problems
Arthritis	Urinary incontinence	Psychological problems
Abdominal gas	Insomnia	Kidney problems
Low blood pressure	Irritability	Varicose vein problems
Constipation	Hereditary diseases	Nose bleeds
Convulsions	Back pain	Blood in the stools
Itching	Headaches	Blood in urine
Depression	Meningitis	Sinusitis
Diabetes	Edema (swelling)	Urinate frequently
Diarrhea	Operations / surgery	Urinate at night
Easily bruised	Loss or gain of weight	Prostate problems
Numbness	Kidney stones	Cancer
Epilepsy	Shaking	**Reserved for woman**
Skin eruptions (redness)	Foot problems	No menstruation
Dizziness / vertigo	Cardiac problems	Abdominal cramps
Loss of consciousness	Blood circulation problems	Abundant menstrual flow
Cold extremities	Respiratory problems	Painful menstruation
Fatigue	Eye problems	Vaginal loss
Fractures	Digestive problems	Menopause symptoms
Shivers	Sexual problems	Are you pregnant?

I give Dr. Grey C. Gardner, DC my consent for treatment at Van Chiropractic Clinic.
I declare that all the above information is complete and exact to the best of my knowledge.

Patient Signature ______ Date ______