Appointment Details
Date:____________________
Time:____________________

Health History

Is this a WCB injury? Please inform us immediately if yes.

Full Name:____ Date:_________________________
Address: ____
City: ____________________________________ Province:___________ Postal Code: ______________
Home Phone:____________________ Bus Phone:__________________ Cell Phone:_________________
Email address: ____
Birth Date (D/M/Y) : __________/_________/_________ Age: ______________ Sex: M F
Marital Status: single married widowed divorced common law
Name of Spouse/Common Law (if applicable): ____
How many children do you have? (if applicable): ____
Occupation:____
AHC #: ________________________________

Who referred you to our clinic? ____
Have you seen a Chiropractor before? Yes No If yes, how long ago? ___________________
Have you seen a Massage therapist before? Yes No If yes, who? _________________________
Name of Medical Doctor:____

What is your major concern? ____
Date of onset: ____
Have you had this condition or a similar condition before? Yes No
Does your pain radiate to other parts of your body? Yes No
If yes, where?____
What aggravates your condition?____
What makes it better?____
Are you using any home remedy for this problem? Yes No
If yes, what? (circle all that apply) Over-the-Counter Medication (ex. Advil, Tylenol)
Ice Heat Stretching Other? ____
Is this condition getting worse? Yes No Constant Comes and Goes
Is this condition interfering with: Work Sleep Daily Routine Exercise
Have you had any other forms of treatment? Yes No
If yes, please explain: ____
How long has it been since you really felt good?____
Any other complaints?____

Have any **<u>X-Rays</u>** been taken of your area of concern, back or neck? Yes No
If yes, when and where? ____

Check any of the following diseases that you have had:

- ☐ Pleurisy
- ☐ Cancer
- ☐ Thyroid
- ☐ AIDS / HIV
- ☐ Arthritis
- ☐ Mental Disorders
- ☐ Eczema
- ☐ Other____
- ☐ Diabetes
- ☐ Anemia
- ☐ Bronchitis
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Asthma

Please check any body signals that you are currently experiencing or that have caused you problems in the last 2 years:

MUSCULO-SKELETAL

- ☐ neck pain/stiffness
- ☐ pain between shoulders
- ☐ low back/hip pain
- ☐ pain or weakness: arms, hands, fingers, legs, feet, buttock, toes
- ☐ arthritis/swollen joints
- ☐ spinal curvature
- ☐ difficulty walking
- ☐ jaw problems/ TMJ
- ☐ muscle cramps/ twitches

CARDIO-VASC-RESP

- ☐ chest pain
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ stroke (TIA)
- ☐ shortness of breath
- ☐ heart problems
- ☐ chronic fatigue
- ☐ swollen hands/feet
- ☐ heart attack
- ☐ bruise easily
- ☐ atherosclerosis

NEUROLOGICAL

- ☐ nervousness/depression
- ☐ poor concentration
- ☐ poor memory
- ☐ loss of sleep
- ☐ convulsions/seizures
- ☐ dizzy/light-headedness
- ☐ fainting/shakes/ trembles
- ☐ headaches/migraines
- ☐ numbness, tingling

DIGESTIVE

- ☐ excessive gas/bloating
- ☐ lack of thirst or appetite
- ☐ excessive thirst or appetite
- ☐ abdominal cramping
- ☐ weight gain/loss
- ☐ heartburn/ulcers/indigestion
- ☐ black/bloody stool
- ☐ diabetes
- ☐ constipation
- ☐ diarrhea/ loose stools
- ☐ colitis
- ☐ liver/gall bladder trouble
- ☐ hemorrhoids

E.E.N.T.

- ☐ thyroid problems
- ☐ sinus problems
- ☐ difficulty swallowing
- ☐ visual disturbance
- ☐ hearing problems
- ☐ ringing in ears
- ☐ earaches
- ☐ loss of smell/taste

GENITO-URINARY

- ☐ kidney infection/stones
- ☐ urination problems
- ☐ increased urinary frequency
- ☐ kidney/bladder/ prostate
- ☐ sexual dysfunction
- ☐ infertility

OTHER

- ☐ hernia
- ☐ skin sensitivity
- ☐ bruise easily
- ☐ contagious skin condition

WOMEN ONLY

- ☐ menstrual problems
- ☐ excessive cramps/pain
- ☐ irregular cycle
- ☐ menopause
- ☐ breast pain/lumps
- ☐ last period start date:_____________
- ☐ pregnant: Yes No Unsure

How many glasses of water do you drink daily? ____

Are you currently on a program of:

Vitamins/Minerals/Herbs/oils? Yes No Type & amount/day:_________________________________

Exercise? Yes No describe routine/frequency:_____________________________________

Are you frequently ill? Yes No

Are you experiencing an energy loss or fluctuating energy levels? Yes No

Do you have trouble sleeping? Yes No How old is your mattress? _______________________

Do you have any allergies? Yes No If yes, specify:__________________________________

How many meals do you eat each day?____

Do you have intolerance to dairy products? Yes No

If no, how much dairy do you consume daily?____

Do you have a family history of:

Stroke (TIA'S) Yes No Diabetes Yes No Heart Disease Yes No

Arthritis Yes No Cancer Yes No

Date of last complete physical exam:____

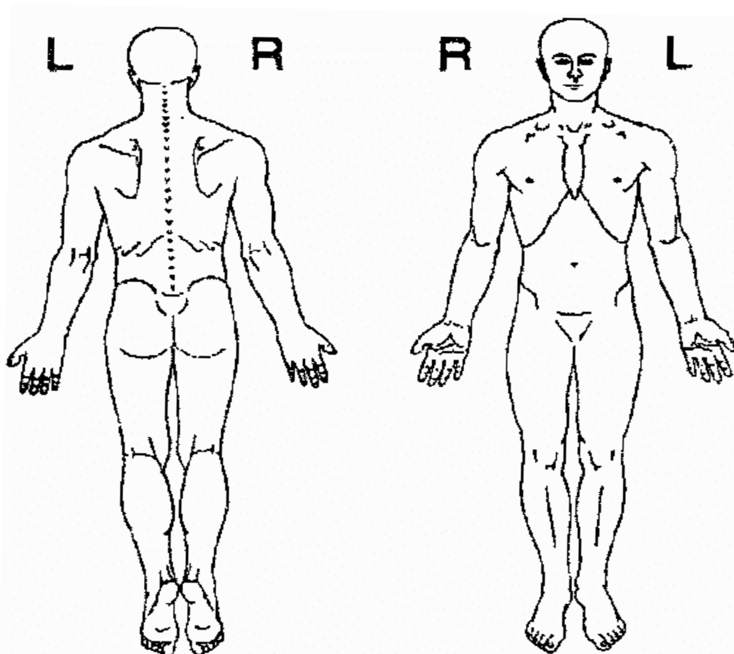
Any findings or concerns to be noted?____

Are you worried or nervous about receiving chiropractic care? Yes No

---

Mark the area(s) of pain or unusual feeling on this body where you feel the described sensations. Use the appropriate symbols and include all affected areas.

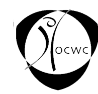
Numbness	●●●
Pins & Needles	OOO
Burning	X X X
Aching	A A A
Stabbing	/ / /
Weakness	W W W



******Please mark on the line below where you would describe your pain level today******

No Pain 0-------1-------2-------3-------4-------5-------6-------7-------8-------9------10 Worst Pain

Stress Test



Have you experienced any of the following stresses?

1. PHYSICAL STRESS:			**If yes, Please explain:**
Birth Traumas (mother or child)	Y	N	....
Slips/falls	Y	N	....
Sports Injuries	Y	N	....
Poor Posture	Y	N	....
Extensive Computer Work	Y	N	....
Surgery	Y	N	....
Repetitive Lifting/Bending	Y	N	....
Continuous Sitting/Standing	Y	N	....
Bone Fracture	Y	N	....
Driving for many hours	Y	N	....
Car Accidents	Y	N	....
Physical Abuse	Y	N	....
Work Injuries	Y	N	....
Sleeping on Stomach	Y	N	....
2. CHEMICAL STRESS:			
Smoker – Amount ?	Y	N	....
Poor Diet	Y	N	....
Caffeine – Amount ? (Coffee/Pop/Tea)	Y	N	....
Excessive Sugar	Y	N	....
Artificial Sweeteners	Y	N	....
Prescription Drugs	Y	N	....
Over-the-Counter Drugs (Tylenol)	Y	N	....
Environmental Pollution (Air/Water)	Y	N	....
Alcohol – Amount?	Y	N	....
3. EMOTIONAL STRESS:			
Relationships	Y	N	....
Career Change	Y	N	....
Children	Y	N	....
Money	Y	N	....
Fast-paced life	Y	N	....
Internalized Feelings	Y	N	....
Perfectionist	Y	N	....
Procrastinator	Y	N	....
Sickness or Loss of Loved One	Y	N	....
Quick Temper	Y	N	....
Verbal abuse	Y	N	....
Recent Move	Y	N	....

4. Which do you feel is your primary stress PHYSICAL / CHEMICAL / EMOTIONAL?

Explain:..

....

Please check the type(s) of care you are interested in:

☐ Pain relief only
☐ Corrective Care (avoids a relapse)
☐ Maintenance/ Wellness Care (proactive approach to health that helps you to continue feeling well)