Health History

Appointment Details
Date:_____
Time:_____

Please inform us immediately if you are booking a WCB injury case

Full Name:_____ Date:_____
Address: _____ Apt# _____
City: _____ Province:_____ Postal Code: _____
Home Phone:_____ Bus Phone:_____ Cell Phone:_____
Email address: _____
Birth Date: _____ Age: _____ Sex: M ○ F ○
Alberta Health Care Number:_____
Marital Status: single ○ married ○ widowed ○ divorced ○ common law ○
Name of Spouse/Common Law (if applicable): _____ # of children_____
Occupation:_____

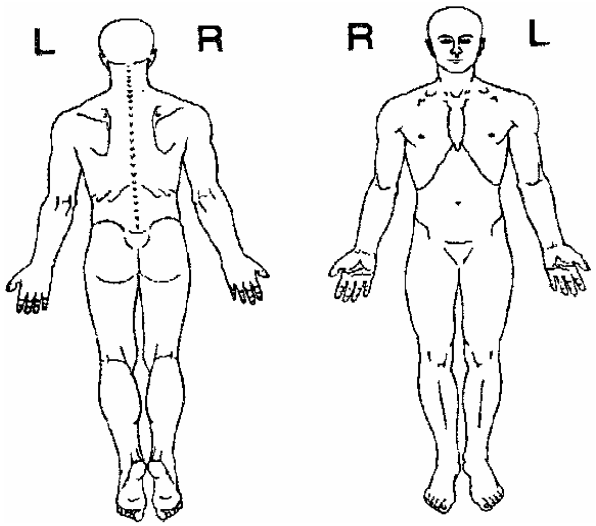
How did you hear about our clinic?

Google ☐ Facebook ☐ Yelp ☐ Radio/Tv Ad ☐ Referred By:_____

Have you seen a Chiropractor before? Yes ○ No ○ If yes, how long ago? _____
Have you seen a Massage therapist before? Yes ○ No ○ If yes, when? _____
Have you seen an Acupuncturist before? Yes ○ No ○ If yes, when? _____
Name of Medical Doctor:_____
Date of last complete physical exam:_____
What is your main 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 (show on diagram below) ○ 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	N N N
Pins& Needles	P P P
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

What aggravates your condition?_____

What makes it better?_____

Are you using any of the following home remedies for this problem? (select all that apply)

Medication ☐ Ice ☐ Heat ☐ Stretching ☐ Other? _____

Is this condition getting worse? Yes ○ No ○ Constant ○ Comes and Goes ○

How has this problem affected your life?_____

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?_____

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

If yes, why?_____

Have any X-Rays been taken of your area of concern, back or neck? Yes ○ No ○

If yes, when and where? _____

How many cups(250ml) of water do you drink daily? _____

Are you currently supplementing any of the following:

Vitamins? Yes ○ No ○ Type & amount/day: _____

Minerals? Yes ○ No ○ Type & amount/day: _____

Essential Oils? Yes ○ No ○ Type & amount/day: _____

Herbs? Yes ○ No ○ Type & amount/day: _____

How many meals do you eat each day? _____

Do you have intolerance to any foods? No ○ Yes ○ (please list): _____

Do you have any allergies? No ○ Yes ○ (specify): _____

Are you frequently ill? Yes ○ No ○

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

What time of day do you feel most energetic?_____ Least?_____

Do you have trouble falling asleep? Yes ○ No ○ How old is your mattress? _____

Do you awaken often in the night? Yes ○ No ○

Do you ever experience restless legs, cramps, or twitches in your muscles? Yes ○ No ○

What are your personal health goals?

_____

_____

_____

Do you exercise? No ○ Yes (specify) ○ _____

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/Gout
☐ spinal curvature/scoliosis
☐ difficulty walking
☐ jaw problems/ TMJ
☐ tendonitis
☐ hernia
☐ fibromyalgia

CARDIO-VASC-LUNG

☐ chest pain
☐ high blood pressure
☐ low blood pressure
☐ stroke (TIA)
☐ shortness of breath
☐ heart problems
☐ blood disorder
☐ swollen hands/feet
☐ heart attack
☐ cough
☐ atherosclerosis
☐ bronchitis
☐ asthma

NEUROLOGICAL

☐ nervousness/depression
☐ poor concentration
☐ poor memory
☐ loss of sleep
☐ convulsions/seizures
☐ dizzy/light-headedness
☐ fainting/shakes/
trembles
☐ headaches/migraines
☐ numbness, tingling
☐ visual disturbance
☐ ringing in ears
☐ ear problems

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
☐ hiatal hernia
☐ IBS
☐ reflux
☐ hypoglycaemia

SKIN - IMMUNE

☐ thyroid problems
☐ sinus problems
☐ chronic fatigue
☐ hives/rashes
☐ athletes foot/jock itch
☐ hair loss
☐ candida
☐ loss of smell/taste
☐ cold sores
☐ HIV/AIDS
☐ acne
☐ skin sensitivity
☐ bruise easily
☐ skin conditions
☐ eczema/psoriasis

GENITO-URINARY

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

WOMEN ONLY

☐ menstrual problems
☐ excessive cramps/pain
☐ irregular cycle
☐ menopause
☐breast pain/lumps
☐last period start
date:_____
pregnant:
Yes ○ No ○ Unsure ○
☐anemia
☐endometriosis
☐ovarian cysts

Have you experienced any of the following stress?

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/skip meals?	Y ○	N ○
Caffeine – Amount ? (Coffee/Pop/Tea)	Y ○	N ○
Excessive Sugar	Y ○	N ○
Artificial Sweeteners/diet products?	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 (pain relief + restoration of spine and joint health)
☐ Maintenance/ Wellness Care (corrective care + ongoing preventative health care to help you live your best)