Health History

Appointment Details
Date:_____
Time:_____

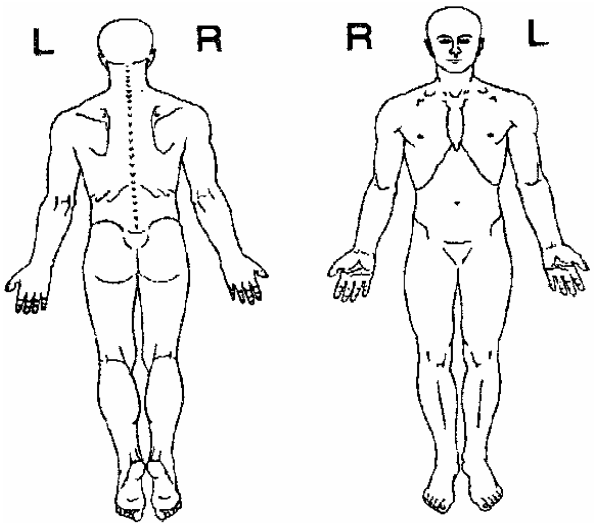
Full Name:_____ Date:_____
Address: _____
City: _____ Province:_____ Postal Code: _____
Home Phone:_____ Bus Phone:_____ Cell Phone:_____
Email address: _____
Birth Date (D/M/Y) : _____/_____/_____ Age: _____ Sex: M☐ F☐
Marital Status: ☐single ☐married ☐widowed ☐divorced ☐common law
Name of Spouse/Common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

How did you hear about our clinic? _____
Have you seen a Chiropractor before? If yes, how long ago? _____
Have you seen a Massage therapist before? If yes, when? _____
Have you seen an Acupuncturist before? If yes, when? _____
Name of Medical Doctor: _____
Date of last complete physical exam:_____

Is this a WCB injury? Please inform us immediately if yes
What is your main concern?_____
Date of onset: _____ Have you had this condition or a similar condition before?
Does your pain radiate to other parts of your body? ☐Yes(show on diagram) ☐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

What aggravates your condition?_____

What makes it better?_____

Are you using any of the following home remedies for this problem? (check 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?

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?

If yes, why?_____

Have any **X-Rays** been taken of your area of concern, back or neck?

If yes, when and where? _____

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

Are you currently supplementing any of the following:

Vitamins? Type & amount/day:_____

Minerals? Type & amount/day:_____

Essential Olis? Type & amount/day:_____

Herbs? Type & amount/day:_____

How many meals do you eat each day?_____

Do you have intolerance to any foods? If Yes(please list)_____

Do you have any allergies? If yes, specify:_____

Are you frequently ill?

Are you experiencing an energy loss or fluctuating energy levels?

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

Do you have trouble falling asleep? How old is your mattress? _____

Do you awake often in the night?

Do you ever experience restless legs, cramps, or twitches in your muscles?

What are your personal health goals?_____

_____

_____

Do you exercise? If 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
☐ candidiasis
☐ 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 stresses?

1. PHYSICAL STRESS:

If yes, Please explain:

Birth Traumas (mother or child) .....
Slips/falls .....
Sports Injuries .....
Poor Posture .....
Extensive Computer Work .....
Surgery .....
Repetitive Lifting/Bending .....
Continuous Sitting/Standing .....
Bone Fracture .....
Driving for many hours .....
Car Accidents .....
Physical Abuse .....
Work Injuries .....
Sleeping on Stomach .....

2. CHEMICAL STRESS:

Smoker – Amount ? .....
Poor Diet/skip meals? .....
Caffeine – Amount ? (Coffee/Pop/Tea) .....
Excessive Sugar .....
Artificial Sweeteners/diet products? .....
Prescription Drugs .....
Over-the-Counter Drugs (Tylenol) .....
Environmental Pollution (Air/Water) .....
Alcohol – Amount? .....

3. EMOTIONAL STRESS:

Relationships .....
Career Change .....
Children .....
Money .....
Fast-paced life .....
Internalized Feelings .....
Perfectionist .....
Procrastinator .....
Sickness or Loss of Loved One .....
Quick Temper .....
Verbal abuse .....
Recent Move .....

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)