Confidential Health History

Personal Information:

Last Name:_____ First Name: _____

Address:_____ City: _____ Prov:_____

Postal Code: _____ Date of Birth (Month/Day/Year): _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Occupation: _____ Employer: _____

Care Card Number: _____ Family Physician: _____

Who may we thank for your referral to our office? _____

Names and ages of children: _____

E-mail address:_____

Chief Complaint

Primary Complaint_____

Other Complaints_____

Please rate the severity of your pain:

0 1 2 3 4 5 6 7 8 9 10

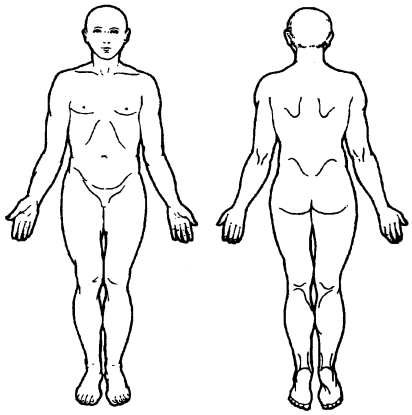
pain-free mild uncomfortable distressing intense unbearable

Did it come on: □ suddenly □ slowly

When and how did this problem begin: _____

_____

Please mark all problem areas:



Have you had this or a similar condition in the past? Y /N

If yes, when and how often? _____

Is the condition: □ improving □ getting worse Is the pain: □ constant □ intermittent

When does it bother you most? (morning, evening, driving, etc.)_____

What makes this condition better?_____

What makes this condition worse?_____

Does the pain radiate anywhere? Y/ N If so, where (down the arm, leg, etc.)_____

Does your condition interfere with: □ work □ sleep □ daily routine □ other_____

What treatment, medications, surgeries or other methods have you tried for this condition?_____

_____

Lifestyle Information:

What are you presently doing to support your health and wellbeing?

□ Regular exercise □ Balanced diet □ Good sleep □ Relaxation time

□ Hobbies □ Drink Water □ Yoga/Stretching □ Prayer/Meditation

Health Information:

What are your objectives in seeking chiropractic care? (please check all that apply)

- ☐ Relief of symptoms
- ☐ Decrease the risk of symptoms returning
- ☐ Decrease the risk of re-injury
- ☐ Improve range of motion/mobility
- ☐ Improve spinal stability
- ☐ Improve nerve function
- ☐ Increase energy level
- ☐ Relieve stress
- ☐ Decrease the risk of arthritis
- ☐ Improve overall health and well-being
- ☐ Other (please list): _____

Have you had previous Chiropractic care? ☐ Yes ☐ No When? _____

What were your results? _____

List any medications you take and for what conditions: _____

Stress History

Please rank your levels of stress in each area as: (mild / moderate / severe)

Physical: _____ Emotional: _____ Chemical: (what we eat, drink & breathe) _____

Health History:

Please check all of the following health concerns that you have experienced, even if you do not think that your answers relate to your present health concern.

Allergies	☐ Yes ☐ No	Heart Condition	☐ Yes ☐ No
Anxiety	☐ Yes ☐ No	Immune System Disorder	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Infertility	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Back Pain	☐ Yes ☐ No	Menstrual Cramps	☐ Yes ☐ No
Bladder Problems	☐ Yes ☐ No	Mood Swings	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Neck Pain	☐ Yes ☐ No
Circulatory/Vascular Disorder	☐ Yes ☐ No	Numbness/Tingling	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Diarrhea	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Digestive Problems	☐ Yes ☐ No	Skin Conditions	☐ Yes ☐ No
Dizziness	☐ Yes ☐ No	Urinary Difficulty	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Vertigo	☐ Yes ☐ No
Heartburn/Reflux	☐ Yes ☐ No	Other: _____	☐ Yes ☐ No

Please list any disease or illness in your family history: _____

_____

Please list any previous falls, accidents or trauma: _____

_____

NAME	SIGNATURE	DATE