

# PATIENT HEALTH HISTORY

## Personal Information

Name: \_\_\_\_\_ Health Card \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Circle One: Married/ Single/ Widowed/ Divorced/ Separated/ Other// No. of Children: \_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone No. \_\_\_\_\_ Relationship: \_\_\_\_\_

Is this an **accident** claim? Yes / No Type: **WSIB/MVA?** Claim #: \_\_\_\_\_

Accident or Injury **Date:** \_\_\_\_\_

Family Doctor; Name and City? \_\_\_\_\_

**Who may we thank for referring you to this office?** \_\_\_\_\_

## Current Health Condition

What is the purpose of your visit today? \_\_\_\_\_

When did you first notice symptoms? \_\_\_\_\_

Have you experienced these symptoms before? **Yes / No**

Is this condition related to: Job/ Auto/ Sports Injury/ Fall/ **Other:** \_\_\_\_\_

Have you received treatment for this condition? **Yes/ No**

If yes, by whom? \_\_\_\_\_ Results? \_\_\_\_\_

What **increases** your symptoms? Sitting/ Standing/ Bending/ Lifting/ Walking/  
(Circle all that apply) Lying down/ Dampness/ **Other:** \_\_\_\_\_

What **decreases** your symptoms? Rest/ Ice/ Heat/ Medication/ Massage/ Nothing  
**Other:** \_\_\_\_\_

Do you feel that your condition is getting: better/ worse/ is constant/ comes and goes

Are your symptoms worse in the: morning/ evening/ at night/ constant all day

Is your pain: sharp/ dull/ achy/ stabbing/ throbbing/ burning/ \_\_\_\_\_

Do you have: numbness/ tingling/ pins and needles / \_\_\_\_\_

Do you currently take any medications? **Yes / No**

**If yes** please list all medications: \_\_\_\_\_

On a scale from 0 to 10, rate the **severity** of your pain (circle one):

*Least* 0 1 2 3 4 5 6 7 8 9 10 *Most*

Does your current **problem interfere with** your ability to:

Sleep/ Work/ Enjoy time with family/ enjoy sports/ hobbies

At its worst, **how old** does this problem make you feel? \_\_\_\_\_

If you don't get this problem corrected, do you think it will get worse over the next 5 years? **Yes / No**

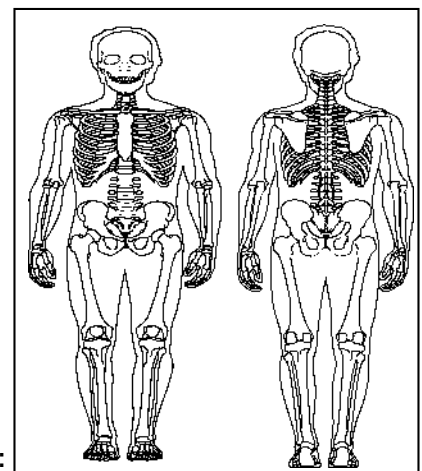
**Have you recently noticed:** loss of bowel or bladder control/  
unexplained weight loss/ sweating at night?

Have you had **x-rays or imaging** in the 2-3 years? **Yes / No**

If yes, **When? Where?** \_\_\_\_\_

On a scale of 1 to 10, rate your commitment to correcting this problem:

*Weak* 1 2 3 4 5 6 7 8 9 10 *Strong*



Please mark on the diagram your area of discomfort and any radiation of pain

## Past Health and Family History

Have you had **surgery**? **Yes/No** **Where/When?** \_\_\_\_\_

Have you **broken** any **bones**? **Yes/No** **Where/When?** \_\_\_\_\_

Any previous: **Childhood** Traumas? \_\_\_\_\_ **Sports Injuries?** \_\_\_\_\_

Motor **Vehicle Accidents?** \_\_\_\_\_ **Work Injuries?** \_\_\_\_\_

**Hospitalization** (other than above): \_\_\_\_\_

**Previous Chiropractic Care: Yes/ No** Doctor's name: \_\_\_\_\_ **Last visit:** \_\_\_\_\_

Do you **smoke** or have you ever smoked? **Yes/ No** How much: \_\_\_\_\_

Do you **exercise** regularly? **Yes/ No** **What type?** \_\_\_\_\_

Do you have a lot of **stress** in your life: **Yes/ No** **Why?/ What?** \_\_\_\_\_

Are you happy with your **current diet/weight?** **Yes/ No** **Why?/What?** \_\_\_\_\_

**Would you be interested in more information about our Nutritional Specialists?** **Yes / No/ Maybe?** \_\_\_\_\_

### Do you or any member of your family suffer from the following conditions:

Self = **S** and/ or Family = **F**

Cancer \_\_\_\_\_ Arthritis \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Conditions \_\_\_\_\_ Epilepsy \_\_\_\_\_

Asthma/Emphysema \_\_\_\_\_ Osteoporosis \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Nerve Disorders \_\_\_\_\_

### **CIRCLE any of the following you have had in the past 6 months:**

**General:** fatigue/ allergies/ loss of sleep/ fever/ headaches/ **other** \_\_\_\_\_

**Nervous system:** numbness/ paralysis/ dizziness/ forgetfulness/ confusion /depression/ fainting  
convulsions/ cold or tingling extremities/**other** \_\_\_\_\_

**Musculo-Skeletal:** low-back pain/ pain between the shoulders/ neck pain/ joint pain or stiffness/  
walking problems/ **other** \_\_\_\_\_

**Cardiovascular/ Respiratory:** chest pain/ shortness of breath/ irregular heart beat/lung problems/  
ankle swelling/ stroke/ varicose veins / **other** \_\_\_\_\_

**Gastro-Intestinal:** poor or excessive appetite/ excessive thirst/ frequent nausea vomiting/ diarrhea  
constipation/ hemorrhoids/ liver problems/ gall bladder problems/ abdominal cramps

**Genito-Urinary:** bladder trouble/ painful or excessive urination/ discolored urine/**other** \_\_\_\_\_

**EENT:** vision problems/ dental problems/ hearing difficulty/ sore throat/ ear aches/ sinus congestion

**Male/ Female:** menstrual irregularity or cramping/ vaginal pain/ breast pain or lumps/ prostate  
problems/ erectile dysfunction/ **other** \_\_\_\_\_

**Why Chiropractic Care?** People go to a Chiropractor for a many reasons. Some go for **short term pain relief (Relief Care)**.

Others are interested in having the cause of the **problem corrected as well as the symptoms relieved (Corrective Care)**.

Others; whatever is malfunctioning in their bodies brought to the **highest state of health possible (Preventative Care)**.

**These are the three phases of care.** Your doctor will weigh your needs and desires when recommending your schedule of care. **How you choose to benefit from Chiropractic is always up to you.**

### ***What Type of Care are you looking for?***

- Preventative Care** - Life Enhancement and Wellness Care
- Corrective Care** - Removing Cause of the Problem
- Relief Care** - Band-Aid Care Only
- Check here if you want the doctor to select the care appropriate for your condition.**

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **CHA:** \_\_\_\_\_