

Patient History Form

Date: _____

Gender: Male Female Mr. Mrs. Miss. Ms. Other: _____

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Tel. (Home): _____ (Work): _____ (Cell): _____

Date of Birth: Day () Month () Year () Age: _____

E-Mail: _____

Yes, you may contact me by e-mail to send appointment reminders, my statements and any important information concerning the clinic

No, do not contact me by e-mail

Occupation: _____ Contact for emergency: _____

Emergency contact numbers: _____ Relationship: _____

How did you hear about our office?

Doctor: _____ Other Health Professional: _____

Friend/Co-worker: _____ Spouse: _____

Other relative: _____ Yellow Pages Newspaper Sign

Lecture/Presentation Internet Work in same building Walked by

Other: _____

Prior Chiropractic Care:

Name: _____ Date: _____

X-Rays taken? Yes No Date: _____

Medical Doctor:

Name: _____ Telephone: _____

X-Rays, MRI, Ultrasound taken: _____

List medications you are taking and for what conditions: _____

Date of last medical exam: _____

Chief Complaint

What is your major complaint? _____

Other complaints? _____

How long have you had this condition? _____

What do you attribute it to? _____

Does the pain travel anywhere? _____

Is it getting progressively worse? Yes No Constant Come and goes

Have you had this or similar conditions in the past? Yes No

What aggravates your condition? _____

What makes it better? _____

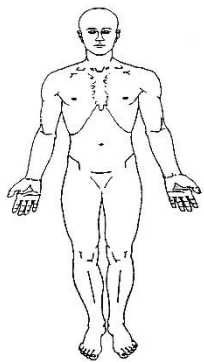
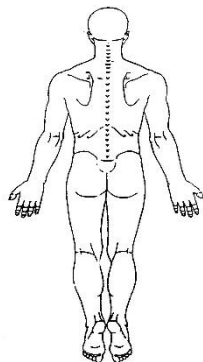
Is this condition interfering with your Work Sleep Daily routine Other: _____

List previous diagnoses and treatments you have received for your present condition?

What do you believe is wrong with you? _____

What do you hope to do or enjoy more when you are better?

Please show any and all area(s) of pain or unusual feeling using the appropriate symbols below.

		<table border="0"> <tr> <td>Numbness</td> <td>●●●●●●●●</td> </tr> <tr> <td>Pin & Needles</td> <td>○○○○○○○○</td> </tr> <tr> <td>Burning</td> <td>xxxxxxxxxx</td> </tr> <tr> <td>Aching</td> <td>*****</td> </tr> <tr> <td>Stabbing</td> <td>//////////</td> </tr> </table>	Numbness	●●●●●●●●	Pin & Needles	○○○○○○○○	Burning	xxxxxxxxxx	Aching	*****	Stabbing	//////////
Numbness	●●●●●●●●											
Pin & Needles	○○○○○○○○											
Burning	xxxxxxxxxx											
Aching	*****											
Stabbing	//////////											

Please draw a line on the scale to describe your pain intensity:

0	10
No pain	The worst imaginable pain

People go to chiropractors for a variety of reasons. Some seek care for relief of pain and discomfort only. Others wish to correct the underlying cause of the problem to increase their health potential and prevent the problem from returning. Please check which type of care you are seeking:

- Relief Care
 Correction
 Wellness

Past Health History:

Please check (☑) if you presently have any of the following conditions.

Please circle those conditions or symptoms which have been a problem to you in the past.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Kidney infection |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Numbness | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Weakness | <input type="checkbox"/> Rashes | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Skin condition | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Trouble urinating | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Sweats | <input type="checkbox"/> Chronic coughing | <input type="checkbox"/> Constipation | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV |

Other health problems? _____

List any surgery, accidents and falls, including year: _____

Have you ever been in a motor car accident? Yes No Year: _____

Have you ever been knocked unconscious? Yes No

List any hospitalization, including year: _____

Family History

Please list any medical conditions in your family: _____

Habits of Lifestyle

Do you smoke? Yes No

Do you exercise? Yes No Please list: _____

Do you belong to a health club? Yes No

Is there anything else the doctor or health team should know?

Thank you.