Ottawa Chiropractic Health Clinic & Physiotherapy

Dr. Alexander Lee, B.Sc., DC
407 Laurier Avenue W. • Ground Floor • Ottawa • ON • K1R 7Y7
Tel: (613) 233-8700 • Fax: (613) 233-8782

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: _____

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

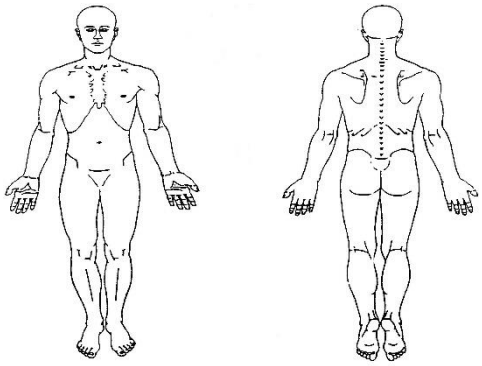
_____

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.



Numbness	●●●●●●●●
Pin & Needles	○○○○○○○○
Burning	xxxxxxxxxx
Aching	**********
Stabbing	/ / / / / / / / / /

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

0 — 10

No pain — **The worse 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.

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

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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: _____

Women: Date of last menstrual cycle (start date): _____
Are you pregnant? ❑ Yes ❑ No ❑ Not sure
Method of birth control used? _____
Number of pregnancies: _____ Number of children: _____

Family History
Please list any medical conditions in your family: _____
_____
_____

Habits of Lifestyle
Do you smoke? ❑ Yes ❑ No Rate you sleep: ❑ Poor ❑ Faire ❑ Good
Do you exercise? ❑ Yes ❑ No Please list: _____
Do you belong to a health club? ❑ Yes ❑ No
Rate your nutrition: ❑ Poor ❑ Faire ❑ Good
Do you take vitamins and minerals? ❑ Yes ❑ No Please list: _____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____

Thank you.

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