CONFIDENTIAL PATIENT HEALTH RECORD

Name:			Date:	
Address:		City:	Postal Code:	
Home Phone: ( )	Work Phone: ( )	Date of Birth D M Y	Age:	Sex: □Male □Female
Cell Phone: ( )	Email address:	Extended Health Insurance? □yes □no Details:		
Occupation:		Employer:		
Marital Status: □single □married □widowed □divorced □common-law		Spouse's Name:		
Do you have children? □yes □no	What are their names/ages?			
Have you ever received chiropractic care before? □yes □no If yes, approximate date of your last visit: Doctors name:				
Spinal x-rays taken in the last 12 months? □yes □no Body Part(s):		How did you hear about our office?		

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which can damage your health expression. With this case history, our goal is to uncover the layers of injury or damage (especially to your nervous system), that result in lowered health. Following your consultation, the doctor may recommend a specific course of examinations in order to determine whether you have spinal nerve stress causing interference with your inborn health potential.

LOSS OF WELLNESS

Most health problems are present for years, (many times undetected), before we are aware of them. Please complete the following questions as closely and carefully as possible…

Please check the appropriate answers:

Your birth process…

Was the delivery: □long and/or difficult (#of hours____) □forceps □vacuum extraction □caesarean □breech?
Was your mother given: □drugs □epidural □induced-gel or drip? Other complications? _____

Growth and Development…

Were you taught how to care for your spine?..... □yes □no
Were you breast fed?..... □yes □no How long? _____
Did you have (please circle): childhood falls—accidents—sports injuries—auto accidents—Other: _____

Current Health Habits…

Do you smoke?..... □yes □no ____packs/week
Do you drink alcohol?..... □yes □no ____beverages/week
Do you go to the dentist for regular check-ups? (min.yearly)……. □yes □no
Do you exercise regularly?..... □yes □no
Do you belong to a gym or sports club?..... □yes □no
Sleeping Posture: □side □stomach □back □restless #of pillows_____
How long do you sleep per night? Total____hrs. Sleep Quality (circle): Excellent—Good—Fair—Poor

Rate your stress level on an average day (circle number):

1 2 3 4 5 6 7 8 9 10

Very Low Moderate Very High

SYMPTOMS AND ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Years of uncorrected injury or damage show up as acute or chronic symptoms or health problems.

Main purpose for this appointment: _____

Have you tried anything to get rid of this problem? _____

At its worst, this problem interferes with: ☐your ability to work ☐hobbies/sports ☐family or social time

If you don't get this problem corrected, do you think it will get worse in the next 5-10 years? ☐ yes ☐ no

On a scale of 1 to 10 (10 being the highest), what is your commitment to getting this problem corrected and improving your health? (Circle)

1 2 3 4 5 6 7 8 9 10

Very Low Moderate Very High

Please check any body signals that are or have caused you problems in the last 12-18 months…

Musc.Skel.Code
□ neck pain/stiffness
□ low back pain
□ pain between shoulders
□ pain or weakness (Circle)
-shoulders, arms, hands, fingers
-buttocks, legs, feet, toes
□ cold hands or feet
□ arthritis/swollen joints/bursitis
□ spinal curvature
□ walking problems
□ jaw problems

Imm. Code
□ fever
□ frequent colds
□ bronchitis/pneumonia
□ sinus problems
□ asthma
□ allergies
□ear infection/tonsillitis

Neuro. Code
□ headaches/migraines
□ numbness, tingling or weakness
□ dizzy/light-headed/fainting
□ loss of sleep
□ convulsions/seizures
□ nervousness/depression
□ depression
□ poor concentration/memory

Cardio-Vasc-Resp. Code
□ chest pain
□ high blood pressure (Low BP)
□ stroke (T.I.A.)
□ shortness of breath/cough
□ heart problems
□ fatigue/chronic tiredness

Dig. Code
□ nausea/vomiting
□ excessive gas
□ bloating
□ indigestion/heartburn/ulcer
□ black/bloody stools
□ appetite changes/excessive thirst
□ blood sugar/diabetes
□ constipation
□ diarrhea (Irritable Bowel)
□ colitis
□ liver/gall bladder trouble
□ hemorrhoids
□ weight change…gain/loss

E.E.N.T. Code
□ visual disturbance
□ deafness/hearing problems
□ ears ringing (tinnitus)
□ earaches
□ sore throat (hoarseness)
□ loss of smell/taste
□ difficulty swallowing
□ thyroid problems

G.U. Code
□ kidney problems/stones
□ problems with urination
□ increase frequency
□ kidney/bladder/prostate
□ sexual dysfunction
□ infertility

Women Only:
□ menstrual problems
□ excessive cramps/pain
□ irregular cycle
□ menopause
□ breast pain/lumps
Last menst.period: Date: _____
Pregnant? □Yes □No □Unsure

FAMILY HEALTH HISTORY What significant health concerns have your family members experienced?

Parents/Siblings_____

Spouse/Partner_____

"The spine is the most overlooked and neglected part of a child's health." Do your children suffer from any of the following... (Please circle): earaches, tonsillitis, headaches, allergies, frequent colds (3 or more/year), growing pains, asthma, bronchitis, bedwetting or Other Problems?

By signing here, I verify that the above information is true and accurate regarding my health history.

Signature: _____ Date: _____