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Patient Health Record

Welcome to our Chiropractic Office.

Please fill out our confidential Patient Health Record completely and accurately. Questions may be directed to our qualified Chiropractic Health Assistants/ Technologists. We are honored to assist you in the recovery and/or attainment of your health and well-being through the application of the most recent knowledge and training in the science based health and wellness living strategies.

PERSONAL HISTORY Date:_____Patient Record #:_____

Name: _____
Address: _____
City: _____ Province: _____Postal Code: _____
Home Phone: _____Birth Date: _____
E-mail address: _____
Age: _____ Gender: ❑ Male ❑ Female
Number of Children: _____
Business/Employer: _____
Type of Work: _____
Business Phone: _____
Circle One: Married Single Widowed Divorced Separated
Emergency Contact:
Name: _____Telephone Number: _____
Who may we thank for referring you to this office: _____

CURRENT HEALTH CONDITION

Current/Chief Complaint:

_____

_____

Other Doctors seen for this condition ☐ Yes ☐ No Who? _____
Type of Treatment: _____Results:_____
When did this condition begin?_____
Has this condition occurred before: ☐ Yes ☐ No
Is condition: ☐ Job-related ☐Auto-related ☐Home Injury ☐ Fall
☐ Other_____
Date of Accident: _____
Time of Accident: _____

What aggravates you condition?
☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking ☐ Lying Down
☐ Cold ☐ Dampness ☐ Other_____

What relieves your condition?
☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: _____

Is it getting?
☐ Worse ☐ Constant ☐ Comes / Goes ☐ Better

Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles
☐ Numb ☐ Burning ☐ Constant ☐ Intermittent

Please describe how it feels when this problem is at its worst:

_____

_____

Please place an X on the grade indicating the severity of your pain:
Least ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Worst

Compare this problem at its worst and a time when you feel great. How does this problem at its worst interfere with?

Your ability to work?

_____

Your ability to enjoy your family or your social time?

_____

Your ability to enjoy your hobbies or sports?

_____

At its worst, how old does it 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

Drugs you now take? ☐ Nerve pills ☐ Stimulants
☐ Pain Killers/Muscle Relaxers
☐ Insulin ☐ Blood Pressure Medicine ☐ Other:
_____

Do you suffer from any condition other than that for which you are now consulting us?

_____

_____

_____

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem. Lowest ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Highest

Have you had X-Rays taken in the last six months? ☐ Yes ☐ No
If yes, where?

_____

PAST HISTORY

Please check of describe:

Major Surgery / Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery ☐ Broken bones

☐ Other: _____

PREVIOUS TRAMAS/INJURY (S):

Childhood_____

Sports Injuries_____

Motor Vehicle Accidents_____

Work Injuries_____

Hospitalization (other than above):_____

_____

PREVIOUS CHIROPRACTIC CARE:

☐ None ☐ Yes

Approximate date of last appointment: _____

Doctor’ s name: _____

FAMILY HISTORY

Does any member of you family suffer from the same condition?

☐ Yes ☐ No Who? _____

Have your children ever had a spinal check-up? ☐Yes ☐No If yes, where and when: _____

I, the undersigned, hereby consent to the examination process which includes examination by the doctor and analysis of posture, balance, ranges of motion and muscle tone (Insight Millenium subluxation station) performed by a qualified technician.

Signature: _____Date:_____

Below is a list of diseases that may seem unrelated to the general purpose of your appointment.
However, these questions must be answered carefully as these problems may affect your overall care.

Check any of the following
Diseases you have had

o Pneumonia
o Mumps
o Influenza
o Rheumatic Fever
o Small box
o Pleurisy
o Polio
o Chicken Pox
o Tuberculosis
o Diabetes
o Arthritis
o Epilepsy
o Whooping Cough
o Cancer
o Mental Disorder
o Anemia
o Heart Disease
o Lumbago
o Measles
o Thyroid
o Eczema

Check any of the following you have had in the last 6 months

o Low Back Pain
o Gas/Bloating after Meals
o Pain between Shoulders
o Heartburn
o Neck Pain
o Black / Bloody Stools
o Arm Pain
o Colitis
o Joint Pain
o Walking Problems
o Difficulty Chewing / Clicking Jaw

Nervous System

o Nervous
o Numbness
o Paralysis
o Dizziness
o Forgetfulness
o Confusion / Depression
o Fainting
o Convulsions
o Cold or Tingling Extremities
o Stress

C-V-R

o Chest Pain
o Shortness of Breath
o Blood Pressure
o Irregular Heartbeat
o Heart Problems
o Lung Problems
o Varicose Veins
o Ankle Swelling
o Stroke

General Complaints

o Fatigue
o Allergies
o Loss of Sleep
o Fever
o Headaches

E.E.N.T.

o Vision Problems
o Dental Problems
o Ear Aches
o Sore Throat
o Hearing Difficulties
o Stuffed Nose

Gastro-Intestinal

o Poor / Excessive Appetite
o Excessive Thirst
o Frequent Nausea
o Vomiting
o Diarrhea
o Constipation
o Hemorrhoids
o Liver Problems
o Gall Bladder Problems
o Weight Trouble
o Abdominal Cramps

Male / Female

o Menstrual Irregularity
o Menstrual Cramping
o Vaginal Pain / Infections
o Breast Pain / Lumps
o Prostrate / Sexual Dysfunction

Genit-Urinary

o Bladder Trouble
o Painful / Excessive Urination
o Discoloured Urine

Females Only

When was your last period? _____
Are you Pregnant Y N

Intake

o Water
o Coffee
o Tea
o Alcohol
o Cigarettes
o White Sugar

Personal Satisfaction with Diet

o Highly Satisfied
o Satisfied
o Dissatisfied
o Highly Dissatisfied

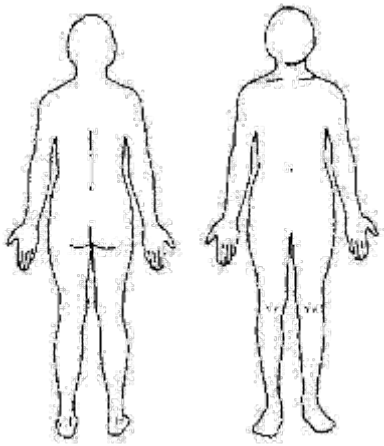
Do you have a regular exercise plan

o Yes
o No

Lifestyle Stress Levels

o High
o Moderate
o Very Little

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



THE HOLISTIC PRACTICE