HEALTH HISTORY FORM _____

Today's Date: _____ Who may we thank for this referral? _____

First Name: _____ Last Name: _____ Preferred First Name:_____

Street Address: _____

City:_____ Province:_____ Postal Code:_____

Home phone:_____ Cellular:_____ Work:_____

Age:_____ Birthdate: (D)_____ (M)_____ (Y)_____ Pregnant: Y / N

Marital Status: _____ Spouse Name:_____

# of Children:_____ their names and ages:_____

Occupation: _____ Employer: _____

Primary Email: _____

INSURANCE

Name of Insurance Provider: _____Group/Policy #:_____ Member ID#:_____

Have you been in a car accident in the last 12 months ? Yes/No If yes: Accident Date: _____

CHIROPRACTIC/PHYSIO HISTORY

Have you been to a chiro/physio before? Yes/No Name of previous chiro/physio: _____

How long were you under care? _____ What were the results?_____

THE PURPOSE OF MY VISIT

- ❑ Symptom relief and preventing its return. _____/_____/_____
- ❑ 100% optimum health and wellbeing on every level available to me.
- ❑ My commitment level to optimal health is (please rate from 0 to 10) : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

MEDICAL INFORMATION

Please check any of the following conditions currently or recently experienced:

- ❑ Neck Pain
- ❑ Headaches
- ❑ TMJ
- ❑ Hearing / Ear Problems: Left / Right
- ❑ Thyroid Problems:Underactive / Overactive
- ❑ Blood Pressure Problems: Low / High
- ❑ Numbness in arms/hands
- ❑ Shoulder Pain: Left / Right
- ❑ Arm Pain: Left / Right
- ❑ Hand/Wrist Pain: Left / Right
- ❑ Recurrent colds/flu
- ❑ Dizziness
- ❑ Allergies/Hay fever: _____
- ❑ Tingling in arms/hands
- ❑ Weakness in grip
- ❑ Low energy/fatigue
- ❑ Mid back/Shoulder blade pain
- ❑ Asthma/Wheezing
- ❑ Pain w/deep breath/expiration
- ❑ Nausea
- ❑ Indigestion/Heartburn/Acid Reflux
- ❑ Tired/Irritable w/out eating
- ❑ Recurrent lung infections/bronchitis
- ❑ Shortness of breath
- ❑ Heart attack/Angina
- ❑ Rib/Chest Pain: Left / Right
- ❑ Heart palpitations
- ❑ Ulcers/Gastritis
- ❑ Low back pain
- ❑ Numbness in legs/feet
- ❑ Frequent/difficulty urinating
- ❑ Muscle cramps in legs/feet
- ❑ Weight Problems
- ❑ Pain/Injury Knee Pain: Left / Right
- ❑ Pain/Injury Ankle Pain: Left / Right
- ❑ Carpal Tunnel Syndrome: Left / Right
- ❑ Gallbladder Problems
- ❑ Kidney Problems
- ❑ Immune Function Problems
- ❑ Chronic Fatigue/Fibromyalgia
- ❑ Skin Problems
- ❑ Prostate Problems
- ❑ Gout Disc Herniation
- ❑ Arthritis
- ❑ Fertility Problems
- ❑ Sexual Functioning Problems
- ❑ Diarrhea
- ❑ Liver Problems
- ❑ Stomach / Digestive Problems
- ❑ Sleeping Problems
- ❑ Anxiety
- ❑ Constipation:_____
- ❑ Hot Flashes
- ❑ Depression
- ❑ Alcohol / Substance Challenges
- ❑ Menstrual irregularities/cramping
- ❑ High Cholesterol
- ❑ Heart Problems:_____
- ❑ Stroke
- ❑ Diabetes: Type 1 / Type 2
- ❑ Aids/ HIV
- ❑ Multiple Sclerosis
- ❑ Weak in legs/feet
- ❑ Sciatica: Left / Right
- ❑ Recurrent Infections:

__ Ear __ Sore Throat

__ Respiratory/Colds

__ Bladder Infections

__ Yeast Infections

- ❑ Family History: diabetes / cancer / heart disease / other family related illness
- ❑ Other conditions:_____

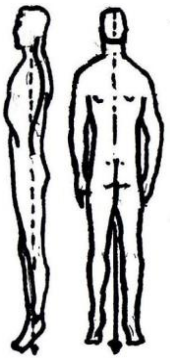
MAJOR HEALTH CONCERNS: Please identify 3 major health concerns you are currently experiencing.
On a scale of **0** to **10,** with **zero** being no pain and **10** being the worst pain, rate your concerns by ***circling the number*** **:**

Problem # 1_____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the problem begin? _____ How did the problem begin? _____
Is it : ❑ Getting better ❑ Getting worse ❑ Staying the same
Pains are : ❑ Dull ❑Ache ❑ Tightness ❑ Throbbing ❑ Spasm ❑ Numb ❑ Sharp ❑ Burning ❑ Shooting
How long does it last ? ❑ It's constant ❑ I experience it on and off during the day ❑ It comes and goes through the week
What activities aggravate this problem ? Please describe: _____
Is there anything that relieves your symptoms ? ❑ No ❑ If yes, please describe: _____

Problem # 2_____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the problem begin? _____ How did the problem begin? _____
Is it : ❑ Getting better ❑ Getting worse ❑ Staying the same
Pains are : ❑ Sharp ❑ Dull ❑Ache ❑ Burning ❑ Tightness ❑ Throbbing ❑ Spasm ❑ Numb ❑ Shooting
How long does it last ? ❑ It's constant ❑ I experience it on and off during the day ❑ It comes and goes through the week
What activities aggravate this problem ? Please describe: _____
Is there anything that relieves your symptoms ? ❑ No ❑ If yes, please describe: _____

Problem # 3_____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the problem begin? _____ How did the problem begin? _____
Is it : ❑ Getting better ❑ Getting worse ❑ Staying the same
Pains are : ❑ Sharp ❑ Dull ❑Ache ❑ Burning ❑ Tightness ❑ Throbbing ❑ Spasm ❑ Numb ❑ Shooting
How long does it last ? ❑ It's constant ❑ I experience it on and off during the day ❑ It comes and goes through the week
What activities aggravate this problem ? Please describe: _____
Is there anything that relieves your symptoms ? ❑ No ❑ If yes, please describe: _____

OFFICE USE ONLY



C1
C2
C3
C4
C5
C6
C7
T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12
L1
L2
L3
L4
L5
S1
C

Leg Length

D __ D __

Weight

Rx Meds :

Sx :

Fx :

MVA's :

Work Related Injuries :

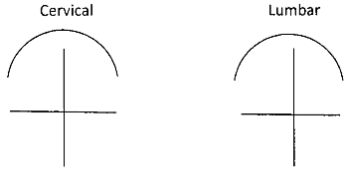
Sports / Rec Injuries :

Injuries at Home :

Injuries at Birth / Childhood :

Patient's body signals for conditions checked off in Medical History section :

Chief:
Other:
Most imp:
Length / differ:
Trauma/MVA/Work:
Tried:
Feel like:
1-10:
Prevent:
S/B/W – freq/inten:
Corrected:
Desire:



Clinical Implications
__VSC CTLS
__Assoc Muscle Dysfunction
__Advanced Arthritis
__Other _____

Plan of Managements
__Corrective Adjustments
__Spinal Exercise
__Nutritional
__Other_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care in this office, it is essential for both the doctor and the patient to be working toward the same objective. Chiropractic science identifies the body as a self-healing and self-regulating being that is consistently adapting to its environment. This is achieved primarily through the central nervous system. Chiropractic has only one goal: to remove nervous system interference in the form of spinal dysfunction, thus restoring and maintaining the integrity of the spinal cord and its nerve roots.

These are vital communication pathways, essential for proper health, which travel to every organ, tissue, and cell in the body, including this immune system. Chiropractors use specific chiropractic adjustments to reduce and remove nervous system interference, done either by hand or by instrument. This allows the proper flow of informational messages from the brain along these nerve pathways to every part of the body. This is critical for optimal health and well-being. We do not offer to diagnose or treat any disease or condition other than spinal dysfunction, nor do we offer advice regarding treatments prescribed by others. However, if during the course of your chiropractic care we encounter non-chiropractic or unusual findings, we will advise you on a possible referral. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of someone who specializes in that area. Be advised this will not interfere with your current chiropractic care plan.

INFORMED CONSENT TO CHIROPRACTIC TREATMENT – FORM L

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic.
In particular you should note: a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures; b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote; c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment; d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.
I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.
I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments. I intend this consent to apply to all my present and future chiropractic care.

_____
Date

_____ _____
Patient Signature Witness Signature

_____ _____
Patient's Printed Name Witness Printed Name