Core wellness centre - 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:_____ Gender:_____ Birthdate: (D)_____ (M)_____ (Y)_____ Pregnant: Y / N

Marital Status: _____ Spouse Name:_____

# of Children:_____ their names and ages:_____

Occupation: _____ Employer: _____

Primary Email: _____

INSURANCE

Insurance Provider: _____Group/Policy#:_____Member ID#:_____Spouse DOB:_____

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:_____

Name:_____ **Date:**_____

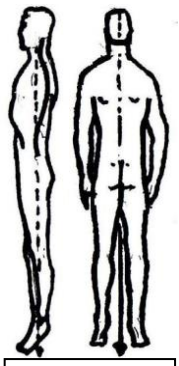
MAJOR HEALTH CONCERNS: Please identify 3 major health concerns you are currently experiencing.
On a scale of **0** to **10,** with **zero** being no pain and **10** being the worst pain, rate your concerns by ***circling the number*** **:**

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

Kemp's
C/S + -
L/S + -

Weight
_____

Rx Meds :

Sx :

Fx :

MVA's :

Work Related Injuries :

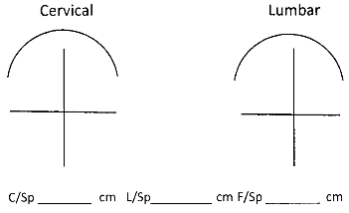
Sports / Rec Injuries :

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 / Dx
__VSC CTLS
__Assoc Muscle Dysfunction
__Advanced Arthritis
__Other: _____
__Acute / mod / chron sprain/strain _____

Prognosis – expected outcome
__excellent; good; fair; poor
Other_____

Consent
__Verbal Consent to Exam

Plan of Managements
__Corrective Adjustments
__Spinal Exercise
__Nutritional
__Other_____
__2x / 24v
__1x / 24v
__2x/__v; 1x/___v; 1x/2wk__v

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 one primary 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.

CONSENT TO CHIROPRACTIC TREATMENT – FORM L

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits: Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks: The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment. The risks include:

Temporary worsening of symptoms - Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.

Skin irritation or burn - Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.

Sprain or strain - Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
Rib fracture - While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
Injury or aggravation of a disc - Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.
Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.
The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
Stroke - Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as a result of injury. A blood clot may form in adamaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke. Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain. Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke. The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance and brain function, as well as paralysis or death.
Alternatives: Alternatives to chiropractic treatment may include consulting other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment. Questions or Concerns: You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition.
DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR
I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

Date: _____

Patient Signature: _____ **Witness Signature:** _____

Patient's Printed Name: _____ **Witness Printed Name:** _____

OfficeAssistant: _____