CENTER FOR HEALTHY LIVING

CHIROPRACTIC HEALTH HISTORY

Date: _____

Last Name:		**First Name:**		**Middle:**	
Address:					
City/Prov:		**Postal Code:**			
Email:		**Gender:**	**M / F / Other**		
Home Ph:		**Work Ph:**		**Cell:**	
DOB: (mm/dd/yy)		**Alberta Health Care #:**			
Occupation:		**Family Medical Doctor:**			
Name of Insurance Provider:					
Emergency Contact (Name):		**Phone:**			
Who may we "Thank" for referring you to our office?					

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic office, we focus on your ability to be healthy.

Our goals are, first to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. Answering the following questions will give us a profile of the specific stresses that you have faced in your lifetime, allowing us to better assess the challenges to your health optimum potential.

Past Chiropractic Care: ❒ Yes ❒ No This Year? ❒ Yes ❒ No Previous Chiropractor:_____

Other wellness professionals currently part of your healthcare team? ❒ Massage Therapist ❒ Acupuncturist ❒ Other _____

List most recent surgeries and dates: _____

Medications (prescription and over-the-counter):

❒ Pain Meds ❒ Anti-inflammatories ❒ Birth Control ❒ Heart Meds ❒ Cholesterol Meds ❒ Other _____

STRESS HISTORY

Please indicate whether you have ever experienced stress in the following areas. Your answers will enable us to determine which factors have contributed to your present health concerns.

YOUR CHILDHOOD YEARS

Stress in our youth sets the stage for problems in our adult life!

Childhood Illness?	❒ Yes ❒ No	Inhaler use?	❒ Yes ❒ No
Repeated/Prolong Antibiotic use?	❒ Yes ❒ No	Prescription Medications?	❒ Yes ❒ No
Car Accident?	❒ Yes ❒ No	Were you vaccinated?	❒ Yes ❒ No
Fall/Jump from a height under 3 feet?	❒ Yes ❒ No	Chiropractic care as child?	❒ Yes ❒ No
Fall/Jump from a height over 3 feet?	❒ Yes ❒ No	Youth Sports?	❒ Yes ❒ No
Other Traumas? (physical/emotional)	❒ Yes ❒ No	Head Trauma?	❒ Yes ❒ No

Comments: _____

ADULT (AGE 18 TO PRESENT)

Smoker?	❒ Yes ❒ No	Contact/Extreme Sports?	❒ Yes ❒ No
Alcohol Consumption?	❒ Yes ❒ No	Drug Use?	❒ Yes ❒ No
Car Accidents?	❒ Yes ❒ No	On a scale of 1 to 10 describe your stress level:	
Fall/Jump from a height?	❒ Yes ❒ No	(1=none, 10=extreme) Occupational: ___ Personal: ___	

Addressing the Issues that brought you to our office . . .

Please check here ❒ "Wish to have Chiropractic Wellness Services", if you have no symptoms or complaint and are here for wellness services. Skip to "Health History".

Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

Your chief complaint: _____

If you are experiencing pain, is it . . . ❒ Sharp ❒ Dull ❒ Comes & Goes ❒ Travels ❒ Constant
❒ Other: _____

Since the problem started is it . . . ❒ About the same ❒ Getting better ❒ Getting worse

What makes it worse? _____

What makes it better? _____

Yes, it interferes with ❒ Work ❒ Sleep ❒ Walking ❒ Sitting ❒ Stairs ❒ Lifting
❒ Hobbies _____ ❒ Leisure _____

Other Doctors seen for this problem (Please list)

- ❒ Chiropractor _____
- ❒ Medical Doctor _____
- ❒ Other _____

HEALTH ISSUES	***Please check all the following health concerns that you have experienced, even if you do not think they relate to your present health condition.***		
Allergies	❒ Yes ❒ No	Heart Condition	❒ Yes ❒ No
Anxiety	❒ Yes ❒ No	Immune System Disorders	❒ Yes ❒ No
Arthritis	❒ Yes ❒ No	Infertility	❒ Yes ❒ No
Asthma	❒ Yes ❒ No	Kidney Disease	❒ Yes ❒ No
Back Pain	❒ Yes ❒ No	Menstrual Cramps	❒ Yes ❒ No
Bladder Problems	❒ Yes ❒ No	Mood Swings	❒ Yes ❒ No
Cancer	❒ Yes ❒ No	Neck Pain	❒ Yes ❒ No
Circulatory/Vascular Disease	❒ Yes ❒ No	Numbness/Tingling	❒ Yes ❒ No
Depression	❒ Yes ❒ No	Osteoporosis	❒ Yes ❒ No
Diarrhea	❒ Yes ❒ No	Sinus Troubles	❒ Yes ❒ No
Digestive Problems	❒ Yes ❒ No	Skin Conditions	❒ Yes ❒ No
Dizziness	❒ Yes ❒ No	Urinary Difficulty	❒ Yes ❒ No
Headaches	❒ Yes ❒ No	Vertigo	❒ Yes ❒ No
Heartburn/Reflux	❒ Yes ❒ No	Other _____	❒ Yes ❒ No

Are there any other health concerns that you believe we should be aware of? (MS, Diabetes, Crohn's, etc.) ❒Yes ❒No

_____

On a scale of Poor, Good or Excellent, please describe your:
Diet _____ Exercise _____ Sleep _____ General Health _____

Which best describes your reason for consulting our office?

- ❒ I have a specific concern and require only help with this concern.
- ❒ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.
- ❒ I want to be healthier five years from now than I am today.