Alliston Chiropractic
Wellness Centre

CONFIDENTIAL PATIENT HEALTH HISTORY (ADULT)

PERSONAL INFORMATION

Name _____ Birth Date _____ Gender _____
Address _____ City/Town _____ Postal Code _____
Phone (Home) _____ Cell _____ Work _____
E-mail _____ Name of Spouse/Partner _____
Business/Employer _____ Type of Work _____
Emergency Contact _____ Phone _____ Relationship _____
Whom shall we thank for referring you to our office? _____
Reason for consulting our office today: _____
Name of Family Doctor _____
Permission to Email You (Please Circle) Yes No

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 to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future.

PLEASE CIRCLE – The initial assessment may include a physical exam and x-rays. Do we have consent to perform these diagnostic tests? Yes No Initial _____

The Beginning Years (To Age 17)
Research is showing that most of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following question to the best of your ability.

	YES	NO	UNSURE
Did you have any childhood illnesses?	○	○	○
Did you have any serious falls as child?	○	○	○
Did you play youth sports?	○	○	○
Did you take/use any drugs?	○	○	○
Did you have any surgery?	○	○	○
Have you fallen/jumped from a height over three feet? (i.e. crib,bunk bed, tree)	○	○	○
Were you involved in any car accidents as a child?	○	○	○

	YES	NO	UNSURE
Did you suffer any other traumas (physical or emotional)?	○	○	○
Was there any prolonged use of medicine such as antibiotics or inhaler?	○	○	○
As a child, were you under regular chiropractic care?	○	○	○

Were you delivered: Naturally ○ C-section ○ Forceps ○
Vacuum ○ Mom induced ○ Unsure○

Adult Years (Age 18 to present)

	YES	NO
Do/did you smoke?	○	○
Do/did you drink alcohol?	○	○
Have you been in any accidents?	○	○
If so, was your nerve system checked by a chiropractor afterwards?	○	○

	YES	NO
Do/did you participate in extreme sports	○	○
Do/did you play contact sports?	○	○
If yes to any of above, did you have your spine and nerve system checked regularly by a chiropractor?	○	○
Have you had any surgery?	○	○

For What?
_____

On a scale of 1-10 rate your stress level (1 = none, 10 = severe) Occupation Stress _____ Personal Stress _____

Please check off **ALL** of the following you have **EVER** had even if you don't think they are related to the current problem:

○ stress	○ arthritis	○ asthma/allergies	○ frequent nausea	○ ulcers/heartburn
○ loss of sleep	○ neck/arm/shoulder pain	○ heart/vascular problems	○ liver/gall bladder problems	○ bladder trouble /painful urination
○ dizziness	○ numbness/tingling	○ shortness of breath	○ diabetes	○ osteoporosis
○ fatigue	○ depression	○ buzzing/ringing in ears	○ pain/stiff in mornings	○ cancer of _____
○ confusion/ forgetfulness	○ pain between shoulders	○ chest pains/heart disease	○ decreased immunity/ frequent colds	○ menstrual irregularity
○ imbalance	○ pinched nerve	○ breast pains	○ thyroid problems	○ sexual dysfunction
○ headaches	○ chronic infections	○ miscarriage(s)	○ upset stomach	○ blood pressure trouble
○ migraines	○ lowback/hip pain	○ menstrual cramps	○ mood swings	○ ankle swelling
○ herniated disc	○ leg/knee/foot pain	○ diarrhea/constipation	○ walking problems	

List all medications you are taking: _____

For women: Are you pregnant? Yes ○ No ○ Trying○ Unsure ○ Date of last menstrual period: _____

If you have no specific symptoms or complaints, and are here mainly for wellness services, please check(✓) here _____ and skip to "**Family Health Profile".**

Those who have symptoms or complaints need to briefly describe the chief area of complaint, including the affect it has had on your life.

_____

If you are experiencing pain, is it: Sharp ○ Dull ○ Comes & Goes ○ Travels ○ Constant ○

Since the problem started, it is: About the same ○ Getting Better ○ Getting Worse ○

What makes it worse: _____

On a scale of 1-10 rate your pain level (1 = none, 10 = severe) _____

It interferes with: Work ○ Sleep ○ Walking ○ Sitting ○ Hobbies ○ Leisure ○

Names of Other Doctors Seen for this Problem:
Chiropractor _____ Medical Doctor _____
Other _____

Please rate your level of commitment to resolving this/these problems(s) (10 being the highest)

1 2 3 4 5 6 7 8 9 10

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have:

Children _____
Spouse/Partner _____
Mother/Father _____
Brother(s)/Sister(s) _____

Sign and Date _____