



## **Adult and Adolescent (13+) History Form – FOR FEMALES**

Please take a few moments to complete this form. Your answers will help us to determine if we can accept your case. If we sincerely believe that your condition will respond more favourably with another health care provider, we will be happy to refer you. If you need help with this form, please do not hesitate to ask our Chiropractic Health Assistants. THANK YOU.

### **Personal Information**

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth D \_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_\_\_ Age \_\_\_\_\_ Marital Status:  M  S  W  D  Sep

Address \_\_\_\_\_

City/Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_

Best contact phone # \_\_\_\_\_ Second phone # \_\_\_\_\_

Business Phone \_\_\_\_\_ May we call you at work?  No  Yes

Email Address \_\_\_\_\_

I AGREE to receive doctor and office correspondence (email addresses will not be shared with anyone outside of this office)

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Is this a motor vehicle accident (MVA) case?  No  Yes Date of accident: \_\_\_\_\_

Is this a WSIB case?  No  Yes has the accident been reported at work?  No  Yes \_\_\_\_\_

Spouse/Partner's Name \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_

Children's Names & Ages \_\_\_\_\_

### **Referrals are our highest compliment; please share with us where you heard about our office:**

Current patient/a friend – name: \_\_\_\_\_

Website  Google search  Social Media (FB/IG)  Yellow Pages  Online Yellowpages.com

Beacon Phonebook  Family Doctor \_\_\_\_\_  Midwife \_\_\_\_\_

Other - please specify \_\_\_\_\_

### **Reason for consulting this office:**

Wellness  Prevention  Symptom Relief

**Current Health Information**

Name of your Medical Doctor & city \_\_\_\_\_

Date of last physical examination \_\_\_\_\_

Is your primary reason for being here a Wellness Check? (Circle one) Yes No

If No, what area of your body are you concerned about? Please describe \_\_\_\_\_

When did this problem begin? \_\_\_\_\_

Has this occurred before?  Yes  No Please describe when \_\_\_\_\_

How often does it happen?  Constant  Daily  Few times per week  Few times per month  Other

Describe the pain:  Sharp  Dull  Ache  Pins & Needles  Numb  Burning  Other \_\_\_\_\_

On a scale of 1-10 please circle the number representing the severity of your pain:

NO PAIN < 1 2 3 4 5 6 7 8 9 10 > SEVERE PAIN

Is it getting:  Worse  Better  Constant  Comes and goes

Do you feel that this problem travels to other areas?  Right arm/hand  Left arm/hand  Right leg/foot

Left leg/foot  Other (please describe) \_\_\_\_\_

What aggravates your condition?  Sitting  Standing  Bending  Lifting  Walking  
 Sleeping  Weather changes  Other \_\_\_\_\_

What relieves your condition?  Ice  Heat  Massage  Stretches  
 Bed Rest  Walking  Medications  Other \_\_\_\_\_

Are there other areas of concern in your body? \_\_\_\_\_

Other doctors/therapists seen for these conditions?  No  Yes \_\_\_\_\_

How would you rate your current level of stress?  Mild  Moderate  Severe \_\_\_\_\_

**How does this problem affect your life with respect to:**

Your ability to work? \_\_\_\_\_

Your ability to enjoy your family/social time? \_\_\_\_\_

Your ability to enjoy activities/sports? \_\_\_\_\_

**Medications you currently take:**  Painkillers  Muscle relaxants  Blood pressure meds  Heart meds

Insulin  for Indigestion  for Depression  for Anxiety

for Asthma  for Allergies  HRT  Other \_\_\_\_\_

Over the counter drugs \_\_\_\_\_

**Natural supplements you currently take:**  Multivitamin  B-complex vitamins  Vitamin C  Calcium

Omega 3/6/9  Prenatal vitamin  Folic acid  Glucosamine

Homeopathic remedies  Other \_\_\_\_\_

**What is your personal satisfaction with your diet?**

Satisfied  Dissatisfied  Highly dissatisfied Why? \_\_\_\_\_

**Do you have a regular exercise program?**  No  Yes What type and how often? \_\_\_\_\_

**Do you smoke?**  No  Yes How much for how long? \_\_\_\_\_

**Do you suffer from any other health conditions?**  No

Diabetes  Heart Condition  Hypertension  Cancer  Respiratory Condition \_\_\_\_\_

Digestive Condition \_\_\_\_\_  Osteoporosis  Other \_\_\_\_\_

Dr. Mike Chambers | Dr. Tanya Chambers | Dr. Blair Neely | Dr. Sarah MacArthur

The following is a list of conditions, which may seem unrelated to your current complaint. However, we would like to assess your full health picture. Please check if you **recently** have had any of the following:

- |   |  |   |   |
|---|--|---|---|
| <i>Musculoskeletal</i>                          | <i>Cardiovascular/Respiratory</i>            | <i>Gastro-Intestinal</i>                          | <input type="checkbox"/> Fibroids/cysts             |
| <input type="checkbox"/> Low back pain          | <input type="checkbox"/> Cold hands/feet     | <input type="checkbox"/> Poor appetite            | <input type="checkbox"/> Infertility                |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Excessive thirst         | <input type="checkbox"/> Miscarriage                |
| <input type="checkbox"/> Neck pain              | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Frequent nausea          | <input type="checkbox"/> Difficult delivery of baby |
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Epidural                   |
| <input type="checkbox"/> Arm pain               | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Constipation             | <input type="checkbox"/> C-section surgery          |
| <input type="checkbox"/> Leg pain               | <input type="checkbox"/> Heart problems      | <input type="checkbox"/> Bloating/Gas             | <i>General</i>                                      |
| <input type="checkbox"/> Joint pain/stiffness   | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Abdominal cramps         | <input type="checkbox"/> Fatigue                    |
| <input type="checkbox"/> Jaw pain/clicking      | <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Heartburn                | <input type="checkbox"/> Irritability               |
| <i>Nervous system</i>                           | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Liver problems           | <input type="checkbox"/> Allergies                  |
| <input type="checkbox"/> Numbness in arm/hand   | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Bladder problems         | <input type="checkbox"/> Poor sleep                 |
| <input type="checkbox"/> Numbness in leg/foot   | <i>Eyes/Ears/Nose/Throat</i>                 | <input type="checkbox"/> Kidney problems          | <input type="checkbox"/> Poor balance               |
| <input type="checkbox"/> Paralysis              | <input type="checkbox"/> Vision problems     | <input type="checkbox"/> Painful/excess urination | <input type="checkbox"/> Poor concentration         |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Loss of smell       | <i>Male/Female Reproductive</i>                   | <input type="checkbox"/> High stress                |
| <input type="checkbox"/> Forgetfulness          | <input type="checkbox"/> Dental problems     | <input type="checkbox"/> Prostate problems        | <input type="checkbox"/> Weight loss                |
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Sore throat         | <input type="checkbox"/> Menstrual pain           | <input type="checkbox"/> Weight gain                |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Earache/infection   | <input type="checkbox"/> PMS                      | <input type="checkbox"/> Fever                      |
| <input type="checkbox"/> Fainting               | <input type="checkbox"/> Hearing loss        | <input type="checkbox"/> Menstrual irregularity   | <input type="checkbox"/> Frequent colds             |
| <input type="checkbox"/> Convulsions            | <input type="checkbox"/> Sinus congestion    | <input type="checkbox"/> Breast pain/lumps        |   |

**Past Health History**

**Please check off any hospitalizations or surgical operations and state years:**

- Appendectomy\_\_\_\_\_  Tonsillectomy\_\_\_\_\_  Gall Bladder\_\_\_\_\_  Hernia\_\_\_\_\_
- Hysterectomy\_\_\_\_\_  Back Surgery\_\_\_\_\_  Broken bones\_\_\_\_\_
- Labour and Delivery\_\_\_\_\_ Other hospitalizations/surgeries\_\_\_\_\_

**Please check off any previous traumas and years:**

- Motor Vehicle Accidents\_\_\_\_\_  Sports injuries\_\_\_\_\_
- Work injuries\_\_\_\_\_  Falls\_\_\_\_\_
- Childhood traumas\_\_\_\_\_  Birth injuries\_\_\_\_\_

Was your own birth:  C-section  Forceps delivery  Breech  Difficult delivery

**Have you ever been to a Chiropractor before?**  No  Yes

Name of previous Chiropractor &city \_\_\_\_\_

Approximate date of last visit: \_\_\_\_\_

**Have you had any x-rays taken in the past 5 years?**  No  Yes Of what area(s)? \_\_\_\_\_

**Please check off any other tests and dates:**  MRI \_\_\_\_\_  CT scan \_\_\_\_\_  Bone Density \_\_\_\_\_  Bone Scan \_\_\_\_\_

Other \_\_\_\_\_

**Family Health History**

Does any member of your family suffer from the same condition as you have now?  No  Yes Whom? \_\_\_\_\_

Do you have a family history of any of the following conditions?  Heart disease  Arthritis  Osteoporosis

Cancer  Diabetes  Hypertension  Stroke  Obesity  Other \_\_\_\_\_

Have your children ever had a spinal check-up?  No  Yes Doctor's name and when \_\_\_\_\_

## Consent for Examination

Today's appointment will include a **Consultation** and **Examination** with one of the doctors. The purpose of this examination is to determine the cause of any health problems that you may be experiencing. We will then determine the best course of treatment for your individual case. The examination may include but not be limited to a postural assessment, range of motion testing of various areas of your spine and extremities, various orthopedic and neurological tests, and a chiropractic spinal exam. The chiropractic examination is a "hands-on" approach so that we can best assess your health. The examination may also include a computerized CoreScore scan, a gait scan analysis, as well as necessary x-rays if indicated.

Congratulations again on seeking chiropractic care!

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

(or Parent/guardian Signature if Patient is under 16 years of age)

\_\_\_\_\_  
Doctor Witness Signature

### ***For Women ONLY***

#### **Consent for x-rays**

This is to certify, to the best of my knowledge, that I am **NOT** pregnant and Dr. Mike Chambers, Dr. Tanya Chambers, Dr. Blair Neely and Dr. Sarah MacArthur have my permission to take x-rays.

For contraception, I am presently using (check all that apply):

Birth control pills     IUD     Other

OR

Day 1 of my menstrual cycle was less than 10 days ago

OR

Not sexually active     Menopausal

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date


(or parent/guardian if patient is under 16 years of age)

\_\_\_\_\_  
Doctor Witness Signature

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Dr. Mike Chambers | Dr. Tanya Chambers | Dr. Blair Neely | Dr. Sarah MacArthur

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## The PSS

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way.

0 = Never      1 = Almost Never      2 = Sometimes      3 = Fairly Often      4 = Very Often

1. In the last month, how often have you been upset because of something that happened unexpectedly?  
0      1      2      3      4
2. In the last month, how often have you felt that you were unable to control the important things in your life?  
0      1      2      3      4
3. In the last month, how often have you felt nervous and "stressed"?  
0      1      2      3      4
4. In the last month, how often have you felt confident about your ability to handle your personal problems?  
0      1      2      3      4
5. In the last month, how often have you felt that things were going your way?  
0      1      2      3      4
6. In the last month, how often have you found that you could not cope with all the things that you had to do?  
0      1      2      3      4
7. In the last month, how often have you been able to control irritations in your life?  
0      1      2      3      4
8. In the last month, how often have you felt that you were on top of things?  
0      1      2      3      4
9. In the last month, how often have you been angered because of things that were outside of your control?  
0      1      2      3      4
10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?      0      1      2      3      4

(office use only-  
Score) \_\_\_\_\_