Personal Health History

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Name:____Today's Date: ______________________________

Address:____ City: _______________Postal Code: ___________

Home Phone: ________________________ Cell: ___________________________ Business:_______________________________

Email: ____ M/F Age: _____ Date of Birth: __________________

Occupation: _______________________________________ Employer's Name: _____________________

S / M / D /W /O _______________________ Name of Spouse/Partner: ______________________________________

Names and ages of Children: ____

Who may we thank for referring you to our office? ____

Name of previous chiropractors: ____

When was your last visit? _______________________________ How long were you going for? ___________________

Your Health Profile:

What health concerns do you feel we can address for you at Urban Health Group?
____

____

Please rate the severity of this condition (1=mild, 10=worst imaginable) ____

When did this episode start? ______________________ Have you had this before and when? ____________________

Since this began, is it worse, better or about the same? ____

What makes it worse? ___________________________What makes it better? _______________________

Does this condition interfere with your: work school leisure sleep sports/exercise other: __________________________________

Other doctors seen for this condition:

Name: _____________________________________ Date: _______________ Diagnosis:___________________________________

Name: _____________________________________ Date: _______________ Diagnosis:___________________________________

General History:

Are you currently seeing any other health practitioners as part of your health care team?

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Medical doctor   Naturopath   Acupuncturist   Registered Massage Therapist   Other: ___________________________________

Please check all symptoms you have ever had, even if they do not seem related to your current problem:

- ☐ Headaches
- ☐ Sinus trouble
- ☐ Jaw pain
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Frequent colds/flus
- ☐ Allergies/ Hay fever
- ☐ Asthma
- ☐ Chronic cough
- ☐ Thyroid trouble
- ☐ Fatigue
- ☐ Sleeping trouble
- ☐ Depression
- ☐ Ear ache
- ☐ Fainting/ dizziness
- ☐ Loss of balance
- ☐ Ringing in ears
- ☐ Blurred vision
- ☐ Neck pain
- ☐ Shoulder/ arm pain
- ☐ Pins and needles in arms
- ☐ Numbness in fingers
- ☐ Cold hands
- ☐ Midback pain
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ High/low blood pressure
- ☐ Anemia
- ☐ Tension/ Nervousness
- ☐ Irritability
- ☐ Indigestion
- ☐ Ulcers
- ☐ Intestinal gas/bloating
- ☐ Low back pain
- ☐ Arthritis
- ☐ Skin problems
- ☐ Numbness in legs/feet
- ☐ Leg or foot pain
- ☐ Constipation
- ☐ Urinary problems
- ☐ Menstrual pain/ irregularity
- ☐ Swelling in joints
- ☐ Cold feet
- ☐ Hip pain

Please list any accidents and/or injuries (Automobile, bicycle, sports, playground, etc.) and the date of the injury:

____ Date: ____________________

____ Date: ____________________

____ Date: ____________________

Please list any surgeries you have had and the date of the surgery:

____Date: ____________________

____Date: ____________________

____Date: ____________________

Please list any medications you are currently taking (prescription and non-prescription):

____

____

Birth Record:

What type of birth did you have (vaginal, c-section, forceps, etc.)?____

Were there any complications during your mother's pregnancy or during your birth?

____

____

For Women:

Are you pregnant? Y N Date of last menstrual period: ____

If pregnant, when is your due date? ________________Name of OBGYN or midwife _______________

Where will you be birthing your baby? Hospital Home Birthing Centre Other ______________

General Health:

How would you describe your current health? ____

How would you describe your family's health? ____

Do you use any of the following (Please circle)? Tobacco Alcohol Coffee/Tea Soft drinks Milk

Level of stress in your life (1-10): _______ Is your health better, worse or the same as 5 years ago? ____________

Explain why you think this is: ____

Goals and Expectations:

People visit a chiropractor for a variety of reasons. In order to serve you better, we'd like to know which of the following health care options you are most interested in and intend to follow through with. Please check which description suits you best:

- ☐ Preventative Care – Wellness and life enhancement care
- ☐ Maintenance Care- Removing symptoms and their cause, with periodic routine maintenance visits
- ☐ Relief Care- Band-aid care to remove symptoms only
- ☐ Unsure, I would like the doctor to select the type of care that is most appropriate for my condition.

Consent:

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature ____Date: ________________