KINSTRUCT HEALTH

CONFIDENTIAL PATIENT HEALTH HISTORY

Welcome to our clinic. Please fill out the following form to the best of your ability to help *Dr. Laura Dobrinsky* provide you with the best care possible. If you have any questions, or need help filling out the form please let us know. If under the age of 16, please fill out the pediatric intake form and provide guardian signature.

PERSONAL INFORMATION

Name: ________________________________ Date of Birth: _____________ Age: _____

Address: ____

City *Province* *Postal Code*

Home Phone: _________________ Work: _____________________ Cell: ____________________

E-Mail: ______________________ Occupation: ________________ Gender: M F

Spouse/Partner: ________________________ Children: ( ) _____________________________________

Emergency Contact: _____________________ Relation: ____________ Phone: _________________

How did you hear about us? ____

Is it okay to use your email to send reminders/office emails? □ Yes □ No

What is the nature of this visit? □ Wellness □ Complaint □ Injury □ Other: ________________

HEALTH INFORMATION:

Medical Doctor: ________________________ Phone: ___________________________________

Last Physical Exam: _____________________ Have you had any spinal x-rays? □ Yes □ No

Please list any health conditions you have been treated for in the last year?

____

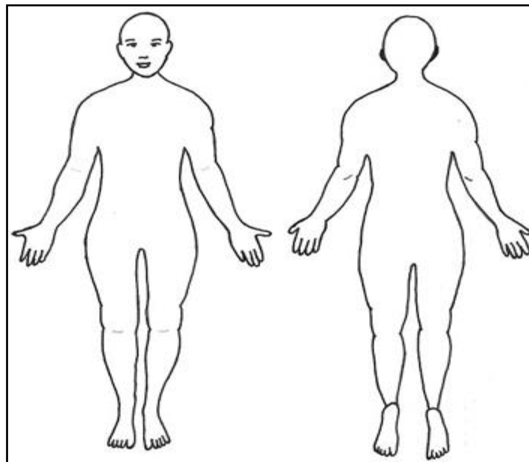
Have you had previous chiropractic care? □ Yes □ No If yes, have you been adjusted? □ Yes □ No

What was the reason for your visit? _______________________ Date of last chiropractic visit? ___________

COMPLAINT DIAGRAM:

Please code areas of pain or discomfort. Add any addition information, or sensations

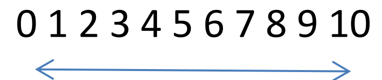
Sharp	xxx
Tingling/Numbness	///
Burning	+++
Deep/Achy/Dull	ooo
Tightness	TTT



Please indicate your present level of pain/discomfort by circling a number

(10 being the worst pain you have ever experienced)

0 1 2 3 4 5 6 7 8 9 10



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PATIENT SYMPTOMS:

What is your chief complain? ____

When did it start? ____

The complaint is getting: □ *WORSE* □ *BETTER* □ *SAME*

The complaint started: □ SUDDENLY □ GRADUALLY

What may have caused the problem? ____

Duration of symptoms: □ CONSTANT □ HOURLY □ DAILY □ ON & OFF □ INFREQUENT

Has the complaint affected your **daily activities**? □ Yes □ No How? ______________________________

Has the complaint affected your **ability to sleep**? □ Yes □ No How? ______________________________

Has the complaint affected your **appetite**? □ Yes □ No How? ______________________________

Has this happened before? □ Yes □ No If so, when? __________________________

Have you had to miss work? □ Yes □ No Last day of work:__________________

Is the complaint worse at a certain time of day? □ Yes □ No What time? ______________________

Does the weather affect your complaint? □ Yes □ No How? __________________________

What *Aggravates* your complaint? _______________________ What *Relieves it?* _______________________

MEDICAL HISTORY:

Please list all medications you are on:

____

Please list any hospitalizations or surgeries (include year):

____

Please list any supplements that you are on (include brand if known):

____

When was the last time you were on antibiotics? _____________________

Do you get a cold or respiratory illness often? □ Yes □ No

Do you smoke? □ Yes □ No How many packs/week? _____________

Do you drink alcohol? □ Yes □ No How many drinks/week? ______________

Do you have a bleeding disorder? *Yes* *No*

Do you have a heart condition? *Yes* *No*

Do you have a pacemaker? *Yes* *No*

Do you have any allergies? *Yes* *No* *If yes, to what?* ______________________

CONFIDENTIAL PATIENT HEALTH HISTORY

FEMALE ONLY:

Are you pregnant? □ Yes □No □ Not sure If yes, how may weeks? ______

Are you breastfeeding? □ Yes □ No

Are you presently trying to conceive? □ Yes □ No

Are you taking birth control? □ Yes □ No Reason: ____

What was the 1st day of your last period? ______________ Average length of your cycle: _____ days

Do you have irregular or painful periods? □ Yes □ No

Any pelvic conditions/surgeries (such as PCOS, endometriosis, fibroids, hysterectomy):

____

Are you on HRT? □ Yes □ No

Please mark any of the following conditions or symptoms that you have now (√) or have experienced (x):

O Headaches	O Pain in Hands or Arms	O Chest Pains
O Neck Pain	O Numbness in Hands or Arms	O Heart Attack
O Sleeping Problems	O Pain in Legs or Feet	O High Blood Pressure
O Low Back Pain	O Numbness in Legs or Feet	O Stroke
O Nervousness	O Fatigue	O Cancer
O Tension	O Depression	O Painful Urination
O Irritability	O Lights Bother Eyes	O Diabetes
O Dizziness	O Loss of Memory	O Diarrhea
O Pain between Shoulders	O Shoulder Pain	O Constipation
O Neck Stiff	O Sinus	O Stomach Upset
O Joint Swelling	O Shortness of Breath	O Heartburn/Reflux
O Fever	O Asthma	O Weight Loss
O Loss of Balance/light headedness	O Allergies	O Loss of Smell or Taste
O Ringing in Ears	O Cold Hands	O Menstrual Cramps
O Jaw/TMJ Problems	O Cold Feet	O Menopause

Other:

____

CONFIDENTIAL PATIENT HEALTH HISTORY

What level of **STRESS** are you experiencing: None 1 2 3 4 5 Severe

How well do you cope with stress: □ Poorly □ Ok □ Well

What is your energy level: □ Exhausted □ Low □ Good □ Amazing

How often do you exercise? □ Daily □ 3-5 days/week □ 1-2 days/week □ Infrequent

What is your go to for breakfast? ____

Do you eat fresh organic/pesticide free produce daily? □ Yes □ No

Do you consume dairy? □ Yes □ No

Do you have any sort of special diet or lifestyle? (i.e. gluten free, Paleo, dairy free, vegan, etc.)

Explain;____

FAMILY HISTORY:	Heart Disease	Diabetes	Arthritis	Cancer	Other: _________
Father's side	O	O	O	O	O
Mother's side	O	O	O	O	O

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow *Dr. Laura Dobrinsky* to examine me for further evaluation, which may include X-Rays and/or thermal and EMG analysis.

Patient Signature____**Date**________________

*The body is powerful. In order to keep it healthy we need to do our part to keep it functioning optimally. **Movement is the key to life, and living**. In order to remain active throughout our lives we require a healthy musculoskeletal system, but most importantly **a healthy nervous system**. Most health problems are present for years before signs or symptoms are noticed, and uncorrected injuries or damage can show up as acute or chronic symptoms or health problems later in life. By correcting and restoring function to the body, you can greatly reduce your chances of joint related disability later in life, and help ward of disease and illness. In addition, a healthy nervous system and body contributes to better posture, energy, mood and overall health, and **well-being**.*