Westview
Chiropractic Health Centre

11 King Street, Miramichi, N.B. E1N 2M9
Tel: (506) 773-5053 Fax: (506) 773-5056

Confidential Patient Health Record

Date: __________________ Medicare Number: ______________________

Patient Name: ____ Gender: M or F
(first) (middle) (last)

Birth Date: Day__________ Month__________ Year__________ Age: __________

Address: ____
(Street) (City) (Province) (Postal Code)

Phone: Res:( ) ______________________ May we leave a message? □ Yes □ No

Bus/Cell: ( ) ______________________ May we leave a message? □ Yes □ No

Emergency Contact: ______________________ Phone ( ) ______________

Occupation: ______________________ Employer: ______________________

Do you have insurance that partly covers Chiropractic care? Yes No

Do you have insurance that partly covers Massage Therapy? Yes No

If yes, please indicate: ______________________________

Previous Chiropractor: ____________________ City ______________ Prov.______

Last visit to Chiropractor: ______________________________________

Previous Massage Therapist: ________________ City______________ Prov.______

Last visit to Massage Therapist: ______________________________________

Medical Doctor: ______________________ City ______________ Prov.______

How did you hear about our office: referred by Friend (name)______________________

Phone book___ Sign___ Other ______________

Is this visit related to injury incurred at work? Yes No

If yes, please give **date and details** of injury:

____

____

Is this visit related to a recent motor vehicle accident? Yes No

If yes, please give **date and details** of injury:

____

____

What are your main goal(s) in visiting our office? (Please ✓ all that apply)

- ❑ Relief of a particular symptom or problem.
- ❑ Wellness and/or preventative health care.
- ❑ Athletic and/or performance enhancement.
- ❑ Other

SYMPTOM DIAGRAM

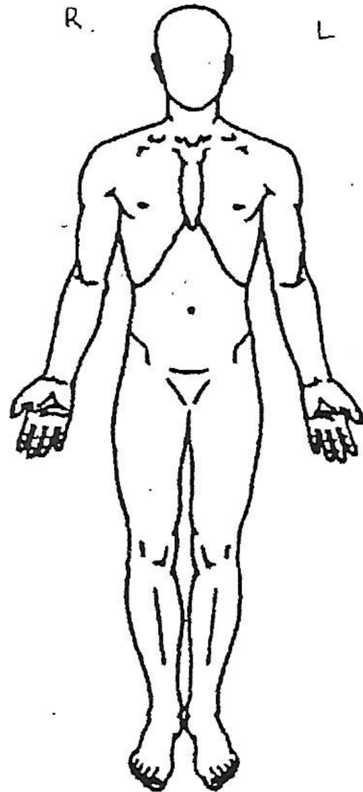
PATIENT NAME:______________________________ **DATE:**____________________

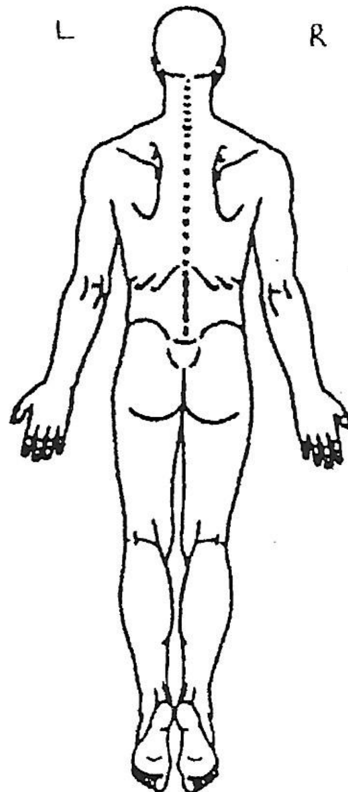
FILE #:__________________

On the diagrams provided below, please mark the areas on your body which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include ***all* areas.** Use **<u>only</u>** the symbols provided below. If you have no current symptoms (eg. Checkup), please **check (√)** here.

Symbols:

Numbness	====
Burning	xxxx
Dull & aching	+ + +
Pins & needles	....
Stabbing & sharp	////
Stiff & tight	2222





FRONT **BACK**

Also, on the scale below, please **CIRCLE** the level of pain or discomfort you are currently experiencing:

0	1	2	3	4	5	6	7	8	9	10

No Pain Unbearable Pain

SYMPTOMS: PAST & PRESENT

PATIENT NAME:______________________________ **DATE:**____________________

FILE #:________________

Please CIRCLE any conditions or symptoms **PRESENTLY** causing you problems. Please check (√) beside those conditions or symptoms which have been a problem to you **IN THE PAST**.

General Symptoms
Loss of consciousness
Blackouts
Headache
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convultions
Loss of sleep
Numbness
Pain or tingling
Nervousness
Loss of weight

Muscles & Joints
Stiff neck
Back ache
Swollen Joints
Painful tail bone
Foot trouble
Shoulder pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Arthritis
Weakness or loss of strength

E.E.N.T.
Blurred vision
Failing vision (one/both eyes)
Crossed eyes
Double vision
Eye pain
Deafness
Earache
Ringing, buzzing, any noise in ears
Asthma
Frequent colds
Sinus infection
Enlarged glands
Enlarged thyroid
Slurred or other speech problems

Difficulty swallowing

Respiratory
Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficulty breathing

Cardiovascular
Bleeding disorder
High blood pressure
Pain over the heart
Stroke
Hardening of the arteries
Varicose veins
Swelling of ankles
Poor circulation
Heart or blood disease
Angina

Genitourinary
Trouble urinating
Blood in the urine
Kidney infection
Bed wetting
Prostate trouble

G.U. for Women
Painful menstruation
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Vaginal discharge
Swollen breasts
Lumps in breasts

Skin
Rashes, itching
Bruise easily
Dryness
Boils
Hives (allergy)

Gastrointestinal
Poor appetite
Indigestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Stomach pain
Diarrhea
Constipation
Hemorrhoids
Jaundice
Gall bladder trouble
Intestinal worms
Ulcer
Diabetes

General Questions
(Please **circle** the appropriate answer)

Have you ever had any fractures? YES NO
Have you ever been in a car accident? YES NO
Have you ever been hospitalized? YES NO
Have you ever smoked in the past? YES NO
Are you currently a smoker? YES NO
Do you take medications on a regular basis? YES NO
If YES, what do you take? (Please list name or type of medication).

____

____

For Women Only
Have you ever been on birth control pills?
YES NO
Are you currently taking the birth control pill?
YES NO