Complete Family Chiropractic and Wellness Centre – Dr. Guillet, Dr. Hewitt

428 Westmount Avenue, Unit 1A Sudbury, Ontario P3A 5V8 (705) 525-1221

Date

Patient No.

Adult Health History

PERSONAL HEALTH HISTORY

DD/MM/YYYY
Name: ____ Birthdate: ________________ Age: ________ Gender: ☐M ☐F
Address: ____ City:___________________Province:
____________Postal Code: _______________ Home Phone: _______________________Business
Phone___________________________
Cell Phone: ____________________________Email address: ____
Physician's Name: ___________________________________ Extended Health Coverage: ☐ Yes ☐ No ☐ Not sure
Business/Employer: ____________________________________ Type of Work: __________________________________
Circle one: Married Single Widowed Divorced Separated Spouse's Name _________________Children ____________
Referred To This Office By: ____

CURRENT HEALTH CONDITION

Current Complaint(s):____
____
____
Other doctors seen for this condition: ☐No ☐Yes: Who? ____
Type of Treatment: _________________________________Results____
When did this condition begin? _______________________ Has this condition occurred before? ☐No ☐Yes, ____________
Is the condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐Other:_________________________________
Date of Accident: ____________________________________ Time of Accident: __________________________________
What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Dampness ☐ Other: _______________________

What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: ____
Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐Better

Type of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb
☐ Burning ☐ Constant ☐ Intermittent

On a scale of 1 to 10, 10 being the worst pain ever, rate your level of pain/discomfort: _________________________________
Please describe how it feels when this problem is at its worst:____
____
How does this problem at its worst interfere with:
Your ability to work? ____
Your ability to enjoy family, social, hobbies, sports? ____
If you don't get this problem corrected, do you think it will get worse over the next 5 years? ☐ Yes ☐ No

On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting the problem:__________________

List any medications you are currently taking: ____
____

Have you ever had x-rays taken before? ☐ No ☐ Yes When and where?____
X-ray of what? ____

PAST HEALTH HISTORY

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐Hernia ☐Back Surgery
☐ Broken Bones ☐ Hysterectomy ☐ Other: __________________________________
Major Accidents or Falls: ____
____
Hospitalization (other than above): ____
____
Previous Acupuncture treatment: ☐ None ☐ Acupuncturist's name and date of last visit:_________________________
Previous Chiropractic treatment: ☐ None ☐ Chiropractor's name and date of last visit:__________________________

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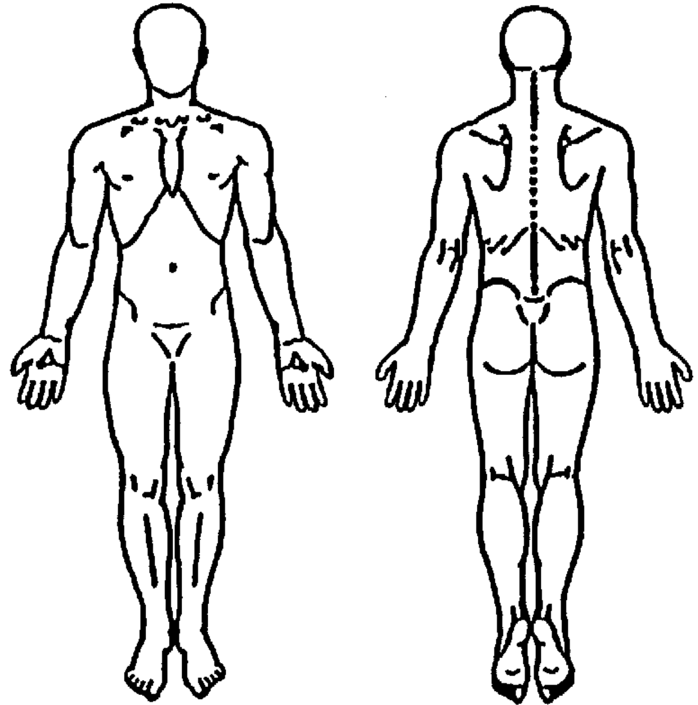
Draw in your face.
Show area(s) of pain or unusual feeling.
Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.
Mark areas of radiation. Include all affected areas.

Numbness	● ● ● ● ● ● ● ● ● ● ● ● ● ● ●
Pins & Needles	○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○
Burning	X X X X X X X X X X X X X X X
Aching	* * * * * * * * * * * * * * *
Stabbing	/ / / / / / / / / / / / / / /



FAMILY HEALTH HISTORY

Does any member of your family suffer from the same condition? ☐ No ☐Yes ________________________________

Is there any diseases/conditions that run in the family? ____

Have your children ever had a spinal check-up? ☐ No ☐ Yes, Where &When?______________________________

YOUR SUCCESS

We want to know how to make this experience a success for you. Please complete the following:

Six months from now we'd be wildly successful with our care because we've accomplished three (3) things.

What are these three things?

1. ____

2. ____

3. ____

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SYSTEMS

Please check the appropriate box for any of the following symptoms which you now have (currently) or have had previously.

P = Previously   **C** = Currently

P C

☐☐ Pneumonia
☐☐ Mumps
☐☐ Measles
☐☐ Influenza
☐☐ Rheumatic Fever
☐☐ Whooping Cough
☐☐ Small Pox
☐☐ Polio
☐☐ Chicken Pox
☐☐ Pleurisy
☐☐ Arthritis
☐☐ Tuberculosis
☐☐ Diabetes
☐☐ Epilepsy
☐☐ HIV
☐☐ Cancer
☐☐ Mental Illness
☐☐ Anemia
☐☐ Heart Disease
☐☐ Bleeding Disorder
☐☐ Hemophilia
☐☐ Thyroid
☐☐ Eczema
☐☐ Fibromyalgia/Chronic Fatigue
☐☐ Colitis
☐☐ Alcoholism

Musculo-Skeletal

☐☐ Low Back Pain
☐☐ Pain Between Shoulders
☐☐ Neck Pain
☐☐ Arm Pain
☐☐ Shoulder Pain
☐☐ Leg Pain
☐☐ Knee Pain
☐☐ Joint Pain/Stiffness
☐☐ Walking Problems
☐☐Difficulty Chewing/Clicking Jaw
☐☐ General Stiffness

Nervous System

☐☐ Nervous
☐☐ Numbness
☐☐ Paralysis
☐☐ Dizziness
☐☐ Forgetfulness/Confusion
☐☐ Depression
☐☐ Fainting
☐☐ Convulsions
☐☐ Cold/Tingling Hands/Feet
☐☐ Always feel cold
☐☐ Always feel warm

Cardiovascular

P C

☐☐ Chest Pain
☐☐ Shortness of Breath
☐☐ Blood Pressure Problems
☐☐ Heart Problems
☐☐ Lung Problems/Congestion
☐☐ Varicose Veins
☐☐ Ankle Swelling
☐☐ Stroke

General

☐☐ Fatigue
☐☐ Allergies
☐☐Loss of Sleep
☐☐ Loss of weight
☐☐ Fever
☐☐ Headaches

Ear, Nose & Throat

☐☐ Deafness
☐☐ Earache
☐☐ Ear ringing/buzzing
☐☐ Vision Problems
☐☐ Eye Pain
☐☐ Nose Bleed
☐☐ Sinus Infection
☐☐ Sore Throat
☐☐ Enlarged thyroid
☐☐Tonsillitis

Digestive

☐☐ Gas/Bloating After Meals
☐☐ Excessive Thirst
☐☐ Frequent Nausea
☐☐ Vomiting
☐☐ Black/Bloody Stool
☐☐ Diarrhea
☐☐ Constipation
☐☐ Hemorrhoids
☐☐ Liver Problems
☐☐ Gall Bladder Problems
☐☐ Weight Trouble
☐☐ Abdominal Cramps
☐☐ Heart Burn/Indigestion

Urinary

☐☐ Bladder Trouble
☐☐ Painful/Excessive Urination
☐☐Discoloured Urine
☐☐ Bed-wetting

Female/Male

P C

☐☐ Menstrual Cramping
☐☐ Menstrual Irregularity
☐☐ Vaginal Pain/Infections
☐☐ Breast Pain/Lumps
☐☐ Prostate Trouble
☐☐ Sexual Dysfunction

Female Only

When was your last period?______

Are you pregnant?
☐No ☐Yes ☐ Not sure
If Yes, Due Date_________________
Weeks pregnant: ________

Intake

☐Coffee #cups/day:_____________
☐ Tea #cups/day:_______________
☐ Alcohol Amount/day:_________
☐ Cigarettes Amount/day:________
Years smoking:____________
☐ Soft Drinks Amount/day:_______
☐ Vitamins (incl brand): _________
____
____

Personal satisfaction with diet

1 2 3 4 5
I-----------I----------I----------I----------I
Satisfied Neutral Dissatisfied

Do you have a regular exercise program?

☐ No ☐Yes: _________________
____
____

Lifestyle Stress Levels

☐ High
☐ Moderate
☐ Low

Have you received any vaccines in the last year?

☐ No ☐Yes: _________________
____
____
Any Reactions?: _______________
____