FAMILY WELLNESS CENTRE
DR. JON DIPLOCK, CHIROPRACTOR

CONFIDENTIAL PATIENT HEALTH HISTORY

Welcome to our wellness clinic. Please fill out the following form to the best of your ability to help Dr. Jon Diplock 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? _____

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

□ Other: _____

HEALTH INFORMATION

Medical Doctor:_____ Phone:_____

Last Medical Visit:_____ Have you ever had Spinal X-rays? □ Yes □ No

Please list any health conditions that you have been treated for in the past year: _____

_____

Have you had Chiropractic care in the past? □ Yes □ No If Yes, have you ever been adjusted? □ Yes □ No

What was the reason for your Chiropractic visit? _____

Date of last Chiropractic visit: _____

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LIFE CHALLENGES AND COMPLAINTS

Do you have any present complaints or health challenges? Please explain: _____

_____

When did it begin? _____

Have you had this problem before? _____

This complaint started: □ SUDDENLY □ GRADUALLY □ UNKNOWN

The complaint is getting: □ WORSE □ BETTER □ NO CHANGE

What is this interfering with in your life? □ FAMILY □ WORK □ SOCIAL □ DAILY ACTIVITIES

Have you seen anyone about this complaint? If so, who and how did they manage your complaint?

_____

MEDICAL HISTORY

Please list any medications that you are using:

Drug:	Purpose:
_____	_____
_____	_____
_____	_____

Please list any surgeries or hospitalizations (include year):

_____

Please list any supplements you are taking (Include brand if known):

_____

When was the last time you were on antibiotics? _____

Do you often get a cold or respiratory illness? □ YES □ NO

Do you smoke? □ YES □ NO Number of packs/week? _____

Do you drink alcohol? □ YES □ NO Number of Drinks/week? _____

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Please mark any of the following conditions 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: _____

STRESS

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 the main cause of your stress? □ Family □ Work □ Social □ Financial □ Health

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

How often do you exercise? □ Daily □ 3-5days/wk □ 1-2days/wk □ Infrequently

Do you follow any specialized diet or lifestyle (ex. Paleo, Gluten free, Vegan…)?_____

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

Patients Signature_____ **Date**_____

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