City Centre Chiropractic & Wellness

Confidential health history

Name ____ Birth date ____________________ (Age _______)

Address ____

Street City Prov. Postal Code

Phone Numbers: Home (_____) - _____ - _______Work (_____) - _____ - ______Cell (_____) - _____ - _______

E-mail ______________________________________ Occupation ____________________________________

Marital status? Single _____, Married _____, Divorced _____, Widowed _____, Spouse's name ________________

How do you prefer to be addressed? First name ___ Mr. ___ Mrs. ___ Ms. ___ Dr. ___

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

For women: Are you pregnant? ❒Y, ❒N Date of last menstrual period? __________________________

WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

THE BEGINNING YEARS?

Research is showing that many of the health challenges that occur later in life have their origin during the developmental years, some start at birth. Please answer the following questions to the best of your ability.

Check all that Apply

1. Was Your Birth Traumatic?

	YES	NO	UNSURE
Long Delivery?	❒	❒	❒
Difficult Delivery?	❒	❒	❒
Forceps?	❒	❒	❒
Caesarian?	❒	❒	❒
Breach/cephalic?	❒	❒	❒
Induced Labour?	❒	❒	❒

2. Growth and Development

	YES	NO	UNSURE
Fell down the stairs?	❒	❒	❒
Had spinal check ups?	❒	❒	❒
Fell awkwardly out of bed?	❒	❒	❒
Bang your head ?	❒	❒	❒
Childhood sickness?	❒	❒	❒
Had any Accidents?	❒	❒	❒

Had Surgery or took drugs ? ________________________________

Participated in youth sports? ________________________________

3. Current Health Habits Do /did you ever …

Smoke? ________

Drink? _________

Diet (do you eat healthy foods?) __________________

Have you been in any accidents? __________________

Do/did you participate in extreme sports?________________

Have you had surgery ____________________________________

Drugs? (Prescriptive or Non-Prescriptive) ______________________

Vitamins and/or Minerals? ____________________________________

Exercise regularly? ____

Do/did you play any adult sports? _____________________________

On a scale of 1- 10 describe your stress level: Occupational _________, Personal ___________. (1= none, 10 = Extreme)

Your sleeping posture? ❒Side, ❒Back, ❒Stomach. Are you wearing? ❒Custom Orthotics , ❒Heel Lifts, ❒Inner Soles

On a scale of Poor, Good, Excellent describe your: Diet _________, Exercise _________, Sleep _________ General Health _________.

REASON FOR CONSULTING OUR OFFICE?

Briefly describe the chief area of complaint, including the effect it has had on your life. If you have no symptoms or complaints, and you are here for Wellness care, skip to "Family Health Profile".

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If you are experiencing pain, is it … ❒Dull, ❒Sharp, ❒Comes and Goes, ❒Travels, ❒Constant

When did the symptoms start? _______________, Since the problem started, it is … ❒About the same, ❒Getting Worse, ❒Getting Better

What makes it worse? ____

Yes, it interferes with: ❒Work, ❒Sleep, ❒Walking, ❒Sitting, ❒Leisure / sports, others ______________________

Other doctors seen for this problem (please list)

❑ Chiropractor ______________________ ❒ Previous x-rays/Scans ______________________

❑ Medical doctor ______________________ ❒ Others ______________________

PLEASE CHECK (√) ALL SYMPTOMS YOU HAVE EVER HAD, EVEN IF THEY DO NOT SEEM RELATED TO YOUR CURRENT PROBLEM.

❒Headaches	❒Pins and Needles in legs	❒Fainting	❒Neck pain
❒Pins and Needles in arms	❒Loss of smell	❒Loss of balance	❒Ringing in the ears
❒Dizziness	❒Buzzing in the ears	❒Nervousness	❒Tension
❒Loss of taste	❒Drop attacks	❒Numbness in the fingers	❒Irritability
❒Neck stiff	❒Fatigue	❒Depression	❒Back Pain
❒Visual problems	❒Stomach upsets	❒Sleeping problems	❒Cold hands
❒Diarrhea	❒Constipation	❒Heartburn	❒Ulcers
❒Mood swings	❒Cold sweets	❒Problems Urinating	❒Hot flashes
❒Severe Menstrual pains	❒Cold feet	❒Numbness in the toes	❒Fever

List any medication you take now ____

FAMILY HEALTH PROFILE:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

CHILDREN ____

SPOUSE ____

MOTHER ______________________ FATHER ______________________

As a result of my chiropractic care, I would like to: (PLEASE CHECK ALL THAT APPLY)

❒ Feel better quickly ❒ Have a healthier spine
❒ Have a healthier body by keeping my nervous system healthy ❒ Live a healthier lifestyle

Please rate your level of commitment to achieving your goals:
❒0, ❒1, ❒2, ❒3, ❒4, ❒5, ❒6, ❒7, ❒8, ❒9, ❒10
(Not at all) (Complete)

To assist us in better explaining the details of our findings to you, please check only the one best choice to complete each of the following statements about yourself:
I remember important things in my life by ❒ what I see, ❒ what I hear, ❒ what I feel
The primary reason I brush my teeth is to ❒ avoid tooth decay, ❒ make sure I have healthy teeth and gums

INSURANCE INFORMATION:

Is your condition due to an auto accident or job related injury? ❒ Yes, ❒ No
Do you have Health Insurance? ❒ Yes, ❒ No

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me.
I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.
I also give consent for the doctor to examine me in order to determine if chiropractic can help.

Patient's Signature:______________________________ Date______________________