Confidential Health Record

File #

Today's Date: MM / DD / YEAR

Whom may we thank for referring you to our office? NAME _____

○ Google ○ Walk-in ○ Word of mouth ○ Other _____

Is this a motor vehicle accident claim? ○ Yes ○ No **Is this a workers compensation board claim?** ○ Yes ○ No

Personal Information

Name FIRST _____ LAST _____ **Sex** ○ Male ○ Female

Address _____ CITY _____ PROV _____ POSTAL CODE _____

Email Address _____

Phone # HOME _____ CELL _____ WORK _____

Marital Status ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated ○ Common Law

Birth Date YYYY/MM/DD _____/_____/_____ **Age** _____ **Alberta Health Care #** _____

Spouse/Partner Name FIRST _____ LAST _____ ○ Not Applicable

# of Children IF APPLICABLE _____ **Names and Ages** _____

Occupation _____ **Employer** _____

Hobbies/Recreation/Likes _____

Emergency Contact

Name FIRST _____ LAST _____ **Relationship** ○ Spouse ○ Relative ○ Friend

Phone # HOME _____ CELL _____ WORK _____

Current Health Professionals

Medical Doctor NAME _____ PHONE _____

ADDRESS _____ CITY _____ PROV _____ POSTAL CODE _____

Dentist NAME _____ PHONE _____

ADDRESS _____ CITY _____ PROV _____ POSTAL CODE _____

Other NAME _____ PHONE _____

ADDRESS _____ CITY _____ PROV _____ POSTAL CODE _____

Present Health Concerns

What is the PRIMARY reason for seeking out our care? PLEASE CHECK **ONE**. WE WILL BE ASKING YOU MORE DETAILS DURING OUR CONSULTATION

- Wellness - I don't have any symptoms or complaints. I am hear for wellness services as par of a healthy lifestyle
- Headaches/Migraines
- Neck Pain
- Low Back Pain
- Upper Extremity (SHOULDERS/ARMS/HANDS)
- Mid Back Pain
- Lower Extremity (HIPS/LEGS/FEET)
- TMJ
- Other _____

Do you have any other reasons for seeking out our care? PLEASE CHECK **ANY** THAT APPLY. WE WILL BE ASKING YOU MORE DETAILS DURING OUR CONSULTATION

- Headaches/Migraines
- Neck Pain
- Low Back Pain
- Upper Extremity (SHOULDERS/ARMS/HANDS)
- Mid Back Pain
- Lower Extremity (HIPS/LEGS/FEET)
- TMJ
- Other _____

Occupation Impact

What are the repetitive activities you do each day?: Lifting, Computer, Grasping, Hand Tools, Machinery, Phone, In/out of vehicle, Other _____

What are your conditions interfering with?: Work, Sleep, Family Life, Personal Life, Hobbies, Sports

How is your job performance affected? No effect, Minor, Limited, Unable to Perform

Work hours per day _____ **Sitting hours per day** _____ **Heavy labour hours per day** _____

Prior Health History

Previous chiropractic care? No, Yes

DOCTOR OR CLINIC NAME _____ LAST VISIT _____ **Did it help?** No, Yes

Injuries PLEASE LIST INJURIES SUCH AS A **FRACTURES**, **FALLS**, **BROKEN BONES**, **HEAD INJURIES**, **LACERATIONS** ETC,

DATE _____ INJURY _____ DATE _____ INJURY _____

DATE _____ INJURY _____ DATE _____ INJURY _____

Motor Vehicle Accidents PLEASE LIST DATES, TYPE (**REAR END**, **FRONT**, **T-BONE,** OR **OTHER),** AND IMPACT (**HIGH**, **MEDIUM**, OR **LOW**).

DATE _____ REAR END, FRONT, T-BONE, OTHER _____ HIGH IMPACT, MEDIUM IMPACT, LOW IMPACT

DATE _____ REAR END, FRONT, T-BONE, OTHER _____ HIGH IMPACT, MEDIUM IMPACT, LOW IMPACT

DATE _____ REAR END, FRONT, T-BONE, OTHER _____ HIGH IMPACT, MEDIUM IMPACT, LOW IMPACT

Surgeries PLEASE LIST DATES AND PROCEDURE (**ESPECIALLY THOSE THAT REQUIRED GENERAL ANESTHESIA**),

DATE _____ PROCEDURE _____ DATE _____ PROCEDURE _____

DATE _____ PROCEDURE _____ DATE _____ PROCEDURE _____

Allergies PLEASE LIST ANY **ALLERGIES** AND **REACTIONS**

ALLERGY _____ REACTION _____ ALLERGY _____ REACTION _____

Medications

PLEASE CHECK IF YOU ARE TAKING **ANY** OF THE FOLLOWING:

- Stimulants
- Antidepressants
- Blood Thinners
- Muscle Relaxers
- Birth Control
- Insulin
- Acid Reducers
- Blood Pressure
- Pain Killers NSAIDS, ASPRIN, IBUPROFEN

PLEASE LIST **PRESCRIPTION** AND **OVER-THE-COUNTER** MEDICATIONS YOU ARE CURRENTLY TAKING

MEDICATION _____ REASON _____ FOR HOW LONG? _____

MEDICATION _____ REASON _____ FOR HOW LONG? _____

MEDICATION _____ REASON _____ FOR HOW LONG? _____

Supplements

PLEASE LIST ANY **NUTRITIONAL SUPPLEMENTS** YOU ARE CURRENTLY TAKING

SUPPLEMENT _____ SUPPLEMENT _____ SUPPLEMENT _____

SUPPLEMENT _____ SUPPLEMENT _____ SUPPLEMENT _____

Current Lifestyle Choices

Cardio exercise Never 1x/wk 2-3x/wk 4-5x/wk Every Day Occasional 'Weekend Warrior'

Strength training exercise Never 1x/wk 2-3x/wk 4-5x/wk Every Day Occasional 'Weekend Warrior'

Tobacco Never Live(d) With Smoker Quit Smoking Cigarettes/Cigars/Chew _____ PER DAY

Alcohol Never Occasional _____ DRINKS PER WEEK **Coffee/Caffeine** Never Occasional _____ CUPS PER DAY

Water _____ GLASSES PER DAY **Fruits/Veggies** _____ PER DAY **Sugar Snacks** Never Occasional Daily

Hours of Sleep HOURS/NIGHT _____ **Do you feel rested when you wake up?** Yes No **Do you get daily quiet time?** No Yes

Have you had any major life changes in the past year? _____

Rate your stress level MARK 0 = **NONE** / 10 = **EXTREME** Occupational _____ Personal _____

How do you cope/manage your stress? _____

Rate your lifestyle MARK **POOR**, **GOOD**, OR **EXCELLENT** Diet _____ Sleep _____ General Health _____

Systems Review

PLEASE CHECK ALL THAT APPLY. **CIRCLE AREAS THAT ARE OF SERIOUS CONCERN OR MORE PROMINENT.**

Nervous System

- Dizziness
- Seizures
- Loss of Memory
- Slurred Speech
- Loss of Consciousness
- Strokes
- Tremor
- Limb Weakness
- Facial Weakness
- Sleep Disturbance
- Stress
- Numbness
- Headache
- Loss of Balance
- Tinnitus/Ringing in Ears

General

- Chills
- Fatigue
- Night Sweats
- Drowsiness
- Fever
- MS
- Weight Loss/Gain
- Anemia
- Cancer
- Diabetes
- Epilepsy
- Hypoglycemia

Respiration

- Asthma
- Coughing up Blood
- Sputum Production
- Chronic Cough
- Shortness of Breath
- Wheezing
- Bronchitis

Cardiovascular

- Heart Murmur
- High Blood Pressure
- Chest Pain
- Swelling of Legs
- Low Blood Pressure
- Claudication
- Palpitations
- Varicose Veins
- Shortness of Breath
- Angina
- Prior Stoke
- Prior Heart Attack

Gastrointestinal

- Diarrhea
- Indigestion
- Abnormal Stool
- Vomiting Blood
- Belching
- Abdominal Pain
- Nausea
- Heartburn
- Hemorrhoids
- Difficulty Swallowing
- Jaundice
- Constipation

Psychological

- Irritability
- Convulsions
- Memory Loss
- Behavior Change
- Anxiety
- Depression
- Mood Change
- Loss of Appetite
- Confusion
- Insomnia
- Bi-Polar Disorder

Family History

- Autoimmune
- Heart Disease
- Cancer
- MS
- Depression
- Osteoporosis
- Diabetes

For Women Only

- Infertility
- Nursing
- Irregular Cycle
- Painful Menses
- Menopausal
- Pregnant

Your Goals For Care

PEOPLE SEE CHIROPRACTORS FOR A VARIETY OF REASONS. SOME GO FOR RELIEF OF PAIN, SOME GO TO CORRECT THE CAUSE OF PAIN AND OTHERS GO FOR CORRECTION OF WHATEVER IS MALFUNCTIONING IN THEIR BODIES. WE WILL WEIGH YOUR NEEDS AND GOALS WHEN RECOMMENDING YOUR TREATMENT PLAN.

What aspects of your life would you like to have back? _____

What are your expectations in receiving care with us? _____

How would you like us to address your problem? ● Symptomatic Relief Only ● Corrective Care ● Wellness Care

What phrase most accurately reflects your health goals? ● Wellness ● Prevention ● Feel Good ● Symptom Relief

How committed are you to correcting your problems? 0 = **NONE** to 10 = **FULLY** 0 1 2 3 4 5 6 7 8 9 10

How long do you think it will take to reach your health goals in the office? _____

Acknowledgement

An evaluation will be performed which may include a spinal and physical examination, orthopaedic and neurological testing, palpation, specialized instrumentation, posture analysis and radiological examination.

We acknowledge that each patient is personally responsible for their own health through the choices they make and we make ourselves available to assist and help you with your health goals in any way we can. We want you to live a *life improved*.

By signing below, I acknowledge that the information I have provided is accurate and true.

Name _____

Signature _____ **Date** _____