Westheights Chiropractic
10 Westheights Drive, Unit 101
Kitchener, Ontario N2N 2A8

P: 519.744.9904
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E: info@westheightschiropractic.com

Adult and Adolescent History Form

Personal History

Name (As it appears on your health card)_____ Preferred Name_____

Address_____ City_____ Prov._____ Postal Code_____

Home Phone (____) _____ Business Phone (____) _____ Cell Phone (____) _____

E-mail_____

Date of Birth (dd/mm/yyyy)_____ Age_____ Sex: M F

Marital Status: M S W D CL Spouse's Name_____

Number of Children_____Occupation_____Employer_____

Past Chiropractic Care? Y N If yes, when was your last visit_____ Results: Poor Good Great

Name of Previous Chiropractor (if you had one)_____

Name of Medical Doctor (if you have one)_____ City_____

Referred to us by_____

Current Health Concerns

☐ Please check here, if you have no symptoms or complaints and are here for wellness care.

Major Concern(s)_____

Minor Concern(s)_____

When did this problem begin?_____ Has it occurred before? Yes No

What makes it worse? ☐ sitting ☐ standing ☐ bending ☐ lifting ☐ walking ☐ lying down
☐ cold ☐ dampness ☐ other_____

What makes it better? ☐ sitting ☐ standing ☐ bed rest ☐ cold ☐ heat ☐ massage
☐ medication ☐ other_____

Is it getting? ☐ worse ☐ better ☐ constant ☐ comes and goes

Is the problem worse during a certain time of day? Yes No If yes, when_____

Does this interfere with ☐ work? ☐ sleep? ☐ daily routine? ☐ quality of life?

Compare this problem at its worst to a time when you felt great! At its worst, what does it interfere with in your life that you value and how does it make you feel? _____

At its worst, how old does it make you feel? _____

Have you seen anyone else for this concern? Yes No If yes, who? _____

Type of Treatment_____ Results: Poor Good Great

Have you had X-rays taken in the last 12 months? Yes No

If yes, where were they taken? _____

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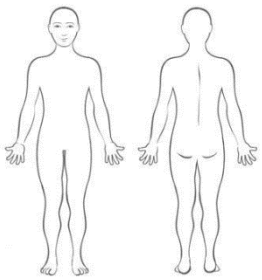
Please use the body diagrams below to mark and describe each type of problem.

Sharp/Stabbing pain XXX
Dull ache OOO
Numbness …….



Tingling ******
Stiff/Tight ///////
Burning pain + + + +

Often, seemingly unrelated symptoms can manifest as another health concern. Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

Check any of the following diseases you have had:

☐ Pneumonia	☐ Mumps	☐ Rheumatic Fever	☐ Small Pox	☐ Fibromyalgia
☐ Pleurisy	☐ Polio	☐ Chicken Pox	☐ Arthritis	☐ Osteoporosis
☐ Tuberculosis	☐ Diabetes	☐ Whooping Cough	☐ Epilepsy	☐ Meningitis
☐ Cancer	☐ Mental Disorder	☐ Anemia	☐ Heart Disease	
☐ Lumbago	☐ Measles	☐ Thyroid	☐ Eczema	

Check if you have had in the past:

☐ Headaches	☐ Tension	☐ Migraine	☐ Sinus	☐ Other
☐ Dizziness	☐ Irritability	☐ Vertigo	☐ Fainting	☐ Fatigue
☐ Loss of concentration	☐ Ears Buzzing	☐ Loss of Balance	☐ Loss of Memory	☐ Depression
☐ Poor coordination	☐ Upper Back Pain	☐ Neck Pain	☐ Low back pain	☐ Stiffness
☐ Radiating Pain	☐ Reduced Mobility	☐ Numbness in leg(s)	☐ Numbness in feet	☐ Weakness
☐ Numbness in hand(s)	☐ Constipation	☐ Diarrhea	☐ Weight Loss	☐ Weight Gain
☐ Shortness of Breath	☐ Difficulty Breathing	☐ Pneumonia	☐ Bronchitis	☐ Asthma
☐ Light Sensitivity	☐ Loss of Smell	☐ Loss of Taste	☐ Ear Pain	☐ Allergies
☐ Menstrual Problems	☐ Breast Pain	☐ Cold Sweats	☐ Face Flushed	☐ Fever
☐ Heart Palpitations	☐ Chest Pressure	☐ Bloating/Gas	☐ Heartburn	☐ Ulcers
☐ Prostate Problems	☐ Urinary Problems	☐ Ankle Swelling	☐ Dental Problems	☐ Indigestion
☐ Menopause Problems	☐ Frequent Colds	☐ Sinus Congestion	☐ Sore Throats	☐ Cold Sores
☐ Vision Changes	☐ Sleeping Problems	☐ Walking Problems		

Events and Habits

The human body is designed to be healthy! There are many events that occur and habits that we pick up throughout our lifetime that may not allow us to maximize the expression of our optimal health potential. Please fill out these few simple questions so that we might better understand your overall health picture and develop an appreciation for the layers of damage that may exist in your body. This may be interfering with your body's innate ability to be well and healthy.

Growing Years	Yes	No	If yes, please explain.
Did you have any notable falls or accidents as a child?	☐	☐	_____
Have you had any notable falls or accidents as an adult?	☐	☐	_____
Have you ever been hospitalized?	☐	☐	_____
Have you had any operations?	☐	☐	_____
Have you had any fractures?	☐	☐	_____
Are you on medications?	☐	☐	_____

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	Yes	No	If yes, please explain.
Are you under mental / emotional stress?	☐	☐	_____
Do you have any physical stresses?	☐	☐	_____
Do you have any occupational stresses?	☐	☐	_____
Are you repetitively exposed to toxins or pollutants?	☐	☐	_____

Are you wearing? ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports ☐ Orthotics

Do you smoke? No Yes If yes, how many per week? _____

Do you take vitamins or minerals? No Yes If yes, please list _____

Do you drink alcohol? No Yes ☐ Daily ☐ Weekends ☐ Sporadically

Do you exercise regularly? No Yes ☐ Daily ☐ Weekends ☐ Sporadically

What position do you sleep in? ☐ Side ☐ Back ☐ Stomach Age of Mattress _____

Type of Mattress? ☐ Spring ☐ Foam ☐ Futon ☐ Waterbed ☐ Other _____

Family History

Please check all appropriate boxes

	Heart Disease	Arthritis-Location	Cancer-Type	Diabetes	Other (Explain)
Mother's side					
Father's side					
Brothers/Sisters					

How would you rate your overall health?

I've never felt worse 1 2 3 4 5 6 7 8 9 10 WOW! I feel great!

Why Chiropractic Care

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (***Relief Care***), which corrects the most recent layers of spinal and neurological damage. Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (***Corrective Care***). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (***Wellness Care***). These are the three phases of care. Your chiropractor will weigh your needs and desires when recommending your schedule of care which best fits your health goals.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ Wellness Care ☐ Corrective Care ☐ Relief Care
☐ Check here if you want the doctor to select the type of care appropriate for your condition

The purpose of our chiropractic office is to serve families of our community to improve their quality of life through chiropractic, focusing on optimum balance of their nervous system. We strive to educate you so that you may understand health and chiropractic and in turn educate and help others.

Dated this_____ day of_____, 20_____.

Patient or (Legal Guardian) Signature: _____

Name (Please Print): _____

"We Enrich The Lives Of Families, One Adjustment At A Time"

www.westheightschiropractic.com