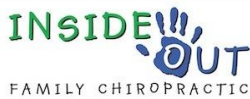


Inside Out Family Chiropractic
**CONFIDENTIAL ADULT PATIENT
 HEALTH RECORD**



Date: _____

27 King St E Bolton, Ont 905-951-9911

PERSONAL INFORMATION

Name _____ Address _____
 City _____ Province _____ Postal Code _____
 Home phone _____ Birthdate _____ Gender M ___ F ___
 Business/Employer _____ Type of work _____
 Business phone _____ E-mail address _____
 Emergency contact _____ Phone _____ Relationship _____
 Whom shall we thank for referring you to our office? _____
 Reason for consulting our office today _____

YOUR HEALTH PROFILE

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and 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. Please, answer every question.

The Beginning Years (To Age 17)

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

	YES	NO	UNSURE		YES	NO	UNSURE
Did you have any childhood illnesses?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Did you suffer any other traumas?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have any serious falls as a child?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	(physical or emotional)			
Did you play youth sports?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Was there any prolonged use of medicine			
Did you take/use any drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	such as antibiotics or an inhaler?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have any surgery?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Were you vaccinated?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you fallen/jumped from a height				As a child, were you under regular			
over three feet? (i.e. crib, bunk bed, tree)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Chiropractic care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Were you involved in any car accidents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Were you delivered : Naturally	<input type="radio"/>	C-section	<input type="radio"/>
as a child?				Vacuum	<input type="radio"/>	Mom induced	<input type="radio"/>
				Unsure	<input type="radio"/>		<input type="radio"/>

Adult Years (Age 18 to present)

	YES	NO		YES	NO
Do/did you smoke?	<input type="radio"/>	<input type="radio"/>	Do/did you participate in extreme sports?	<input type="radio"/>	<input type="radio"/>
Do/did you drink alcohol?	<input type="radio"/>	<input type="radio"/>	Do/did you play contact sports?	<input type="radio"/>	<input type="radio"/>
Have you been in any accidents?	<input type="radio"/>	<input type="radio"/>	If so did you have your spine and nerve system		
If so was your nerve system checked			checked regularly by a chiropractor?	<input type="radio"/>	<input type="radio"/>
by a chiropractor afterwards?	<input type="radio"/>	<input type="radio"/>			
Have you had any surgery?	<input type="radio"/>	<input type="radio"/>	On a scale of 1-10 rate your stress level (1- none, 10-severe)		
For what? _____			Occupational stress _____ Personal stress _____		

Please check off **ALL** of the following you have **EVER** had even if you don't think they are related to the current problem:

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> stress | <input type="checkbox"/> arthritis | <input type="checkbox"/> asthma/
allergies | <input type="checkbox"/> frequent
nausea | <input type="checkbox"/> liver/ gall bladder
problems |
| <input type="checkbox"/> loss of sleep | <input type="checkbox"/> herniated disc | <input type="checkbox"/> shortness of
breath | <input type="checkbox"/> ulcers/
heartburn | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> numbness/tingling | <input type="checkbox"/> heart/ vascular
problems | <input type="checkbox"/> diabetes | <input type="checkbox"/> bladder trouble/
painful urination |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> depression | <input type="checkbox"/> buzzing/ringing
in ears | <input type="checkbox"/> pain/stiff in
mornings | <input type="checkbox"/> cancer of |
| <input type="checkbox"/> confusion/
forgetfulness | <input type="checkbox"/> pain between
shoulders | <input type="checkbox"/> chest pains/
heart disease | <input type="checkbox"/> diarrhea/
constipation | <input type="checkbox"/> menstrual
irregularity |
| <input type="checkbox"/> imbalance | <input type="checkbox"/> pinched nerve | <input type="checkbox"/> breast pains | <input type="checkbox"/> thyroid
problems | <input type="checkbox"/> sexual
dysfunction |
| <input type="checkbox"/> headaches | <input type="checkbox"/> chronic infections | <input type="checkbox"/> miscarriage(s) | <input type="checkbox"/> upset
stomach | <input type="checkbox"/> blood pressure
trouble |
| <input type="checkbox"/> migraines | <input type="checkbox"/> low back/hip pain | <input type="checkbox"/> menstrual
cramps | <input type="checkbox"/> mood swings | <input type="checkbox"/> ankle swelling |
| <input type="checkbox"/> neck/arm/
shoulder pain | <input type="checkbox"/> walking problems | | | |
| <input type="checkbox"/> leg/knee/foot
pain | <input type="checkbox"/> decreased immunity/
frequent colds | | | |

List all medications you are taking: _____

For women: Are you pregnant? Yes ___ No ___ Trying _ Unsure _ Date of last menstrual period: _____

If you have no specific symptoms or complaints, and are here mainly for wellness services, please check (x) here _____ and skip to "**Family Health Profile**". Those who have symptoms or complaints need to briefly describe the chief area of complaint, including the affect it has had on your life.

If you are experiencing pain, is it:

Sharp Dull Comes & Goes Travels Constant

Since the problem started, it is: About The Same Getting Better Getting Worse

What Makes It Worse: _____

It Interferes with: Work Sleep Walking Sitting Hobbies Leisure

Names of other Doctors seen for this problem:

Chiropractor _____

Medical Doctor _____

Other _____

Please Rate your level of commitment to resolving this/these problem(s) (10 being the highest)

1 2 3 4 5 6 7 8 9 10

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:

Children: _____

Spouse: _____

Mother/Father: _____

Brother(s)/ Sister(s): _____

Others: _____

Patient signature _____

Date _____