CENTRE CHIROPRATIQUE CODIAC CHIROPRACTIC CENTRE

1699 Mountain Road
Moncton, NB E1G 1A7
(506)383-1699
www.health@chiropractic.com

Welcome to our clinic!

Confidential Adult Health History

Section I General information

Date: _____
Patient Name: _____ Gender: M or F
(First) (Middle) (Last)
Address: _____
(Street) (City) (Province) (Postal Code)
Telephone: Res.: _____ Bus: _____ Cell: _____
Email: _____
Birth date: Day: _____ Month: _____ Year: _____ Age: _____
Employer: _____
Occupation: _____
Marital Status: Single____ Married____ Divorced____ Widow____ Separated____
Common law____
Spouse's Name: _____ Number of children: _____ Ages: _____

Do you have insurance that partly covers chiropractic care? Yes No
Previous Chiropractor: _____ City: _____
Last visit to this Chiropractor: _____
Present Medical Doctor: _____ City: _____
Date of last medical exam: _____ Any findings?: _____
How did you hear about our office: referred by a friend _____ phone book _____
(name)
Sign _____ Other(describe): _____
Is this visit related to an injury incurred at work? _____
If yes, please give **date and details** of your injury:
_____
_____
Is this visit related to an automobile accident? _____
Date of accident: Day: _____ Month: _____ Year: _____

Section II Present reason for consulting our office:
(Please check only one.)

a) I have a disease/symptom and I am ONLY interested in help with this specific problem……..

b) I have a disease/symptom and I am interested in help with this problem; and in learning how to PREVENT it in the future……...

c) I have a disease/symptom and I am interested in help with this specific problem; in addition I am interested in learning about my health potential and the role of chiropractic in improving my family's health…….

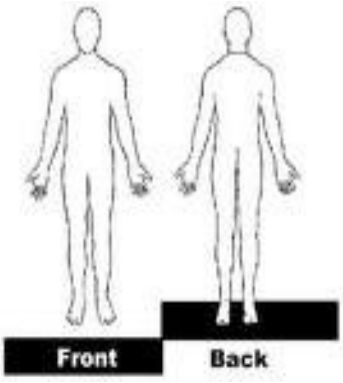
d) I have no special problem; I understand or am interested in the role of chiropractic in my general health care……..

Section III Major symptoms/complaints

Please list any symptoms/complaints: _____

Mark the areas on the drawings where you feel pain or unusual feeling. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	. . . . .
Pins & Needles	O O O O O
Burning	X X X X X
Aching	* * * * *
Stabbing	/ / / / /



What have you tried to get rid of this problem that did not work?

_____

How does this problem interfere with the following areas of your life?
Work: _____
Family: _____
Hobbies: _____
Social Life: _____
On a scale of 1 to 10, with 10 being the highest, rate your commitment to getting rid of this problem:

_____

Section IV Health History

Have you been affected by any of the following in the past 6 months?
O – OCCASIONAL F – FREQUENT C – CONSTANT

__Fever
__Chills
__Fainting spells/dizziness
__Night sweats
__Pain at night
__Unexplained weight loss
__General tiredness
__Headaches
__Depression
__Ear ache
__Ear ringing/buzzing
__Vision changes
__Sinus troubles
__Frequent colds
__Sore throat
__Allergies
__Bronchitis
__Pneumonia
__Difficulty breathing
__Chronic cough
__Asthma
__Heartburn
__Poor digestion
__Bloating/gas
__Ulcers
__Constipation/diarrhea
__Urinary problems
__Bed wetting
__Chest pressure/pain
__Blood pressure problems
__Sleeping problems
__Emotional problems
__Skin problems
__Neck pain/stiffness
__Low back pain
__Pain between shoulder blades
__Legs/feet numbness or pain
__Arms/hands numbness or pain
__Numbness in the face
__Weakness

*For women only
___Heavy flow
___Irregular cycle
___Painful cycles (cramps)
___Vaginal discharge
___In menopause
___menopause is over
___Breast pain
___Pregnant at this time
___Date of last Pap test
___Other _____

Have you ever been diagnosed with any of the following conditions?

___Aneurysm
___Osteoporosis
___Diabetes
___Arthritis
___Epilepsy
___Cancer
___Strokes
___HIV +
___Heart conditions
___Mental disorder
___Hepatitis
___Polio
___Thyroid trouble
___Alcoholism
___Anemia
___Psoriasis
___Sexually transmitted disease
___Tuberculosis
___Rheumatic fever
___Other_____

Are you on any medications? Yes No. If yes, please name drug(s). _____
_____
_____

Have you had any surgeries? Yes No. If yes, please name type of surgery(ies) and date(s).
_____
_____

Have you ever broken any bones? Yes No. If yes, please describe _____
_____

Have you ever been involved in a motor vehicle accident? Yes No. If so, please indicate the approximate date and describe the accident and the nature of the injuries (if applicable).
_____
_____

Have you ever been knocked unconscious? Yes No. If so, for how long? _____

_____

Have you ever been hospitalized? Yes No. If yes, please describe._____ _____

_____

Have you had any side effects to surgery or medications? Yes No. If yes, please explain.

_____

___

Section V Lifestyle

How many hours of sleep do you get per night? _____
Do you wake up tired or well rested? _____
Do you sleep on your back, front or side? _____
What type of bed do you use (i.e. waterbed, soft bed, firm bed, futon)? _____
What type of pillow do you use (i.e. foam, feather, orthopedic or other)? _____
What is your exercise routine? _____
How would you rate your dietary habits? Excellent ___good ___average___ poor___ very poor___
Do you take dietary supplements? Yes No. If yes, please describe: _____
Do you wear custom orthotics in your shoes? Yes No. If yes, please describe_____
Are you interested in discussing potentially getting a new pair of orthotics? Yes No
Would you consider yourself under mental/emotional stress? Yes No. If so, please explain.

_____

Do you smoke? Yes No. If yes, how many cigarettes or cigars per day? _____
Do you drink alcohol? Yes No. If yes, how many drinks per week? _____
Do you drink coffee? Yes No. If yes, how many cups per day? _____
Date of last dental exam. _____

Last Section Family History

	Heart disease	Arthritis	Cancer	Strokes	Mental Illness	Diabetes	Other-explain
Mother's side							
Father's side							
Brother #of___							
Sister #of ___							

If one or both parents have passed away, please indicate the age of death and the cause.

_____

Signature: _____ Date: _____

Thank you!