CONFIDENTIAL

PATIENT HEALTH HISTORY

Date: ___________________

Patient No.: _____________

Name: ____ Sex: ☐ Female ☐ Male

Address: ____

City: ____________________________________ Postal Code:______________________

H. Phone ______________________ W. Phone _____________________ Ext.: ________

Date of Birth: ______/_______/________ Age: ________
yr mm dd

Email:____________________________Website:_________________________________

☐ Please do not add this address for office information sent via email (receipts, office hour changes, etc…)

Employer: _________________________________ Occupation: _____________________

MD: _______________________________ Contact Person: _________________________

Spouse's name: ____

Names of Children and Ages: ____

Referred By: ____

Have you ever received chiropractic care? ☐ Yes ☐ No Who:____________________

When was your last visit:________________For how long did you go:________________
Style/ technique of care:________________ Results were:_________________________

About Your Health

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 optimum health potential. Please take a moment now to fill out these few simple questions so that we might better understand your overall health picture and develop an appreciation of the layers of damage that may exist in your body which are helping to block your body's innate ability to be well and healthy.

Name: ____________________M F
File #: ____________________
Date ______________________

E vents and habits

NEONATAL TO ADULT: Many problems have roots in early spinal and/or neurological damage.

Yes	No		Patient's Comments
		1. YOUR BIRTH PROCESS	
☐	☐	Was your mother on any medication prior or during delivery?	_____________
☐	☐	Did your mother have any falls/ injuries during her pregnancy?	____________
☐	☐	Was it a vaginal birth?	________________________
☐	☐	Was the delivery long and/or difficult?	________________________
☐	☐	Were forceps/ vacuum extraction used?	________________________
		2. GROWING YEARS	
☐	☐	Were you breast fed?	________________________
☐	☐	Any significant childhood injuries or illnesses?	________________________
☐	☐	Any childhood surgeries or prolonged medications?	____________________
☐	☐	Did you have any notable falls/injuries?	________________________
☐	☐	Did you play any sports? Competitive sports?	________________________
☐	☐	Did you suffer any mental/ physical abuse?	________________________
☐	☐	Where you unconscious/ broken bones?	________________________
☐	☐	Did you receive chiropractic care?	________________________
		3. ADULTHOOD	
		PHYSICAL STRESSES	
☐	☐	Have you ever been in a motor vehicle accident?	________________________
☐	☐	Have you had any notable falls/injuries as an adult?	____________________
☐	☐	Sports injuries and/stresses?	________________________
☐	☐	Do you use proper body movement/ lifting procedures	___________________
☐	☐	Do you sustain proper posture?	________________________
☐	☐	Do you exercise regularly?	________________________
		☐ Daily ☐ Weekends ☐ Sporadically	________________________

Please rank your physical stress: (least intense)0______________5______________10 (most intense)

Sleep posture - ☐ side ☐ back ☐ stomach Sleep surface - ☐ mattress ☐ water bed Age:____

During my day I mostly - ☐ sit ☐ stand ☐ walk ☐ on the phone ☐ drive a car/ truck ☐ other (please describe) ____

Yes	No		Patient's Comments
		CHEMICAL STRESSES	
☐	☐	Do you smoke?	________________________
☐	☐	Do you drink alcohol?	________________________
		☐ Daily ☐ Weekends ☐ Sporadically	________________________
☐	☐	Do you eat as healthy as you think you should?	________________________
☐	☐	Are you or have ever been overweight?	________________________
☐	☐	Have you or do you take any drugs; prescription, OTC or recreational?	
☐	☐	Do you work in chemicals or fumes?	________________________

Please rank your chemical stress? (least) 0______________5______________10 (most)

Yes	No		Patient's Comments
		MENTAL/ EMOTIONAL STRESSES	
☐	☐	Occupational/Work stress?	________________________
☐	☐	Mental stress?	________________________

Please rank your mental/emotional stress? (least) 0______________5______________10 (most)

Name: ____________________M F
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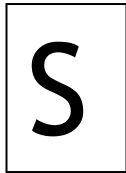
Date ______________________



ymptoms and ill health

As the years go by and the layers of damage increase, it is common to begin to experience symptoms and random bouts of ill health until we are brought to our present state of health.

Present reason for consulting our office:

☐ Maximizing personal and / or family health potential?
☐ Correction and prevention of existing problem?

If you have a specific chief complaint, please describe briefly. *If not, please go to next page.*

____

What do you hope to gain from care at this office? ______________________________
When did this problem begin? ____
How did this problem start? ____

Does the problem/pain radiate or travel anywhere else? __________________________

Pain is… ☐ sharp ☐ dull ☐ throbbing
☐ aching ☐ shooting ☐ nagging ☐ other ____________

Is the problem… ☐ constant ☐ intermittent ☐ worse with movement
Is condition worse… ☐ in the A.M. ☐ in the P.M. ☐ no change
Is condition getting progressively worse? ☐ Yes ☐ No

Is the condition interfering with…
☐ sleep ☐ work ☐ routine ☐ sitting
☐ social life ☐ exercise ☐ recreation ☐ other ____________

The intensity of this problem is 0_____________5_______________10 (most severe)
The % time of the day I suffer is 0%____25%_____50%______75%______100%

What aggravates your condition / pain? ______________________________________
What relieves your condition / pain? _______________________________________

Have you had x-rays, MRI or CAT taken of this area? ☐ Yes ☐ No When__________
Women 10+: Are you pregnant? Yes____ No_____ If yes, how far along are you?_______

Have you had or do you receive any of the following care for this problem or to aid in your healing and growth? If yes, please list any comments you may wish to share.

Chiropractic care? ☐ Yes ☐ No ____
Body work/ Massage therapy? ☐ Yes ☐ No ______________________________
Naturopathic care? ☐ Yes ☐ No _______________________________________
Homeopathic/ Acupuncture care? ☐ Yes ☐ No ____________________________
Osteopathic/ cranial work? ☐ Yes ☐ No _________________________________
Meditation? ☐ Yes ☐ No ____
Psychotherapy/ Psychology? ☐ Yes ☐ No ________________________________
Yoga/Movement therapy? ☐ Yes ☐ No __________________________________
Breath work? ☐ Yes ☐ No ____
Other: ____

Dr. Heather Jones, 379 Ontario Street South, Milton, ON L9T 2N2 Tel: (905) 878-5020 drheather@discoverwellnesswithin.com

Name: ____________________M F
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Have you ever or do you presently suffer from any of the following symptoms? Please list when the symptom first began and the frequency at which you experience it. Please also include any treatments and any medications used.

☐ Headaches	☐ Ears ring	☐ Stiff/painful neck	☐ Nervousness
________________	________________	________________	________________
☐ Depression	☐ Tension	☐ Fatigue	☐ Sleep problems
________________	________________	________________	________________
☐ Chest Pains	☐ Heart/lung trouble	☐ Digestive disorders	☐ Menstrual problems
________________	________________	________________	________________
☐ Numbness or pins & needles in legs	☐ Numbness or pins & needles in arms	☐ Cold feet/hands	☐ Arthritis - where?
________________	________________	________________	________________
☐ Stomach Tension	☐ Asthma	☐ Allergies	☐ Frequent colds/ Sinus
________________	________________	________________	________________
☐ Heartburn	☐ Back Pain	☐ Loss of Balance	
________________	________________	________________	________________

Are there any other medication (include birth control pills, tylenol, prescription drugs, anti-histamines etc.) or treatment (other care) you are receiving?

____

____

Have you ever been hospitalized? If yes for what, how long and what was done?

____

Please list any surgeries and dates?

____

What if any side effects have you experienced from your medications or surgery?

____

Is there a family history of:

	Heart Disease	Stroke	Cancer	Arthritis	Diabetes	Other
Mother's Side	☐	☐	☐	☐	☐	☐ ____________
Father's Side	☐	☐	☐	☐	☐	☐ ____________

Name: ____________________M F
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Date

Any other details you would like the doctor to know?_________________________________

____

____

____

About Your Care

Chiropractic provides three types of care. The first is Initial Intensive Care, which corrects the most recent layer of Spinal and Neurological damage. This care usually reduces or eliminates the symptoms. Then Corrective Care begins, which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

I have read and agree to abide by the above policies.

Patient's Signature: ________________________