PERTH
Family Health Centre
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Name: _____
Date: _____
File #: _____

HEALTH HISTORY

Please check off the circle beside the condition(s) that apply to you currently.

- ◯ Anemia / Bleeding disorders
- ◯ Autoimmune Disorders
- ◯ Cancer
- ◯ Diabetes
- ◯ HIV / Aids
- ◯ Metal Implants
- ◯ Multiple Sclerosis
- ◯ Neurological Disorders
- ◯ Osteoporosis
- ◯ Pace Maker
- ◯ Rheumatoid arthritis
- ◯ Scoliosis
- ◯ Seizures / Epilepsy
- ◯ Stroke
- ◯ Transmittable Diseases
- ◯ Acid Reflux/ Heartburn
- ◯ ADD/ADHD
- ◯ Allergies
- ◯ Anxiety
- ◯ Asthma/ Bronchitis
- ◯ Arthritis/ Joint Pain
- ◯ Back Pain
- ◯ Celiac
- ◯ Gall Bladder Problems
- ◯ Circulation Problems
- ◯ Concussions
- ◯ Constipation
- ◯ Colitis
- ◯ Crohn's
- ◯ Depression
- ◯ Digestive Problems
- ◯ Disc Problems
- ◯ Dizziness / Fainting
- ◯ Emphysema
- ◯ Frequent Colds / Flu
- ◯ Headaches/ Migraines
- ◯ Heart Problems
- ◯ Hernia
- ◯ High / Low Blood Pressure
- ◯ Irritable Bowel Syndrome (IBS)
- ◯ Impotence / Sexual Dysfunction
- ◯ Kidney/Bladder/ Bowel Problems
- ◯ Learning Disability
- ◯ Liver Problems
- ◯ Menstrual Dysfunction
- ◯ Mood Disorders
- ◯ Psychological Problems
- ◯ Nose/ throat problems
- ◯ Osteoarthritis
- ◯ Pregnancy
- ◯ Parkinson's
- ◯ Psychiatric Problems
- ◯ Previous vehicle accidents
- ◯ Previous Surgeries
- ◯ Prostate Problems
- ◯ Recent weight changes
- ◯ Ringing in ears
- ◯ Sciatica
- ◯ Sinus/Drainage Problems
- ◯ Skin Problems
- ◯ Sleep Problems
- ◯ Swallowing problems
- ◯ Thyroid Problems
- ◯ TMJ/ Dental Appliances
- ◯ Tuberculosis
- ◯ Tumor / Malignancy
- ◯ Vertigo / Dizziness
- ◯ Vision / hearing problems

Other: _____

What is your goal of coming here today? _____

_____

Have you ever had a serious illness or health emergency? □ No □ Yes (List all condition(s) including the year):

_____

Have you ever had an operation/surgery? □ No □ Yes (List all surgery(s) including the year): _____

_____

Do you have any genetic disorders or disabilities? □ No □ Yes (Explain): _____

_____

Have you ever had a fall or accident? □ No □ Yes (Explain) _____

_____

Have you ever been unconscious? □ No □ Yes (Explain): _____

_____

Do you wear orthotics or foot supports? □ No □ Yes How old are they? _____

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LIFESTYLE HABITS

How often do you smoke? □ Never □ In the Past □ Occasionally □ Daily □ Other: _____

How often do you drink alcohol? □ Never □ In the Past □ Occasionally □ Daily □ Other: _____

Do you drink coffee? □ No □ Yes How many cups per day? _____

Rate your diet: □ Poor □ Fair □ Medium □ Good □ Excellent

Rate your appetite: □ Poor □ Fair □ Medium □ Good □ Excellent

How many glasses of water do you drink per day? _____

How many meals do you eat per day? _____

How often do you exercise? □ Never □ In the Past □ Occasionally □ Daily □ Other: _____

What is your typical work activity? (Check all that apply): □ Light Lifting □ Heavy Lifting □ Physical Repetition □ Excessive Sitting □ Excessive Standing □ Low Stress □ High Stress □ Other: _____

Are you currently taking any over-the-counter or prescription drug, vitamin/supplement or natural remedy?

□ No □ Yes (Please list the name & reason for taking): _____

_____

CURRENT SYMPTOMS

Select which is true for you:

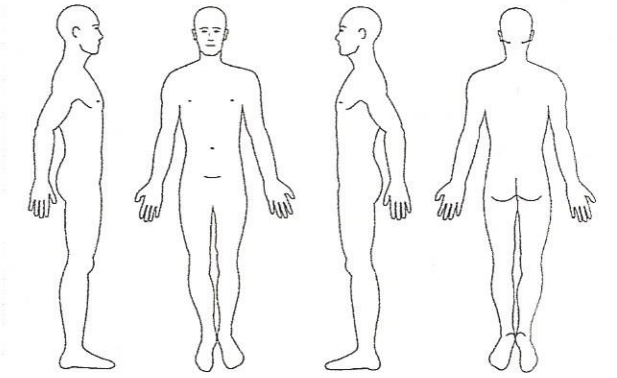
◯ I **DO NOT** have symptoms. I am seeking chiropractic care to maintain wellness.

◯ I **DO** have symptoms. (List all of your symptoms on the lines below)

_____

_____

In this diagram to the right, mark the figures in relation to where you experience your symptoms on your body.



HEALTH GOALS: Select all of your current health and lifestyle goals.

□ Relieve Pain/Discomfort □ Relieve Muscle Tension □ Reduce Medication □ Restore Proper Function

□ Improve Diet/Nutrition □ Increase Energy □ Improve Posture □ Improve Work/Life Balance

□ Improve Self Confidence □ Improve Mobility □ Improve Flexibility □ Increase Self Confidence

□ Restore Emotional health □ Arthritis Management □ Drink More Water □ Treat Illness

□ Strengthen Immune System □ Improve Sleep Habits □ Decrease Anxiety □ Quit Unhealthy Habit

□ Maintain healthy Body Weight □ Reduce Heart Disease Risk Factors □ Improve Athletic Performance

STRESS ASSESSMENT

Select all of the emotional, physical, and chemical stress you have expereienced in the past 3 months:

□ Slip/Falls □ Poor Diet/ Nutrition □ Lack of Sleep □ Occupational Stress

□ Car Accient □ Excessive Sitting □ Death of a Loved One □ Financial Stress

□ Sports Injury □ Excessive Standing □ Hospitalization □ Surgery/ Operation

□ Depression □ Lack of Exercise □ Increase of Exercise □Change in Medication

_____

Patient/Guardian Name & Signature Witness Signature Date