PATIENT HEALTH HISTORY FORM

PERSONAL HISTORY

Name: _____ **Date of Birth:** _____/_____/_____ **(/MM/DD/YY)**

Age: _____ **Gender:** ☐ **M** ☐ **F** **Status:** ☐ **S** ☐ **M** ☐ **W** ☐ **D** ☐ **S**

Address: _____ **City:** _____

Province: _____ **Postal Code:** _____

Telephone #: Hm. (_____**)**_____**-**_____ **Cell (**_____**)**_____**-**_____ **Bus. (**_____**)**_____**-**_____

Email Address: _____ **Number of Children (if applicable):** _____

Provincial Health Card #: _____ **Version Code:** _____ **Expiry Date:** ____/_____/_____
(MM/DD/YY)

Occupation: _____ **Employer:** _____

Address:_____ **Tel.: (**_____**)** _____**-**_____

Name of Medical Doctor: _____ **Tel.: (**_____**)** _____**-**_____

Extended Health Care: _____ **Plan/Claim #**_____ **Certificate/ID#**_____
(if applicable)

Emergency Contact: (Name, Tel. # & Relationship) _____

MVA or WSIB Case? ☐ **YES** ☐ **NO** **If Yes, Date of Accident / Injury:** _____ **(/MM/DD/YY)**

How were you referred to this clinic? ☐ **Phone Book** ☐ **Friend** _____
☐ **Sign** ☐ **Other** _____

Have you seen a Chiropractor before? ☐ **Yes** ☐ **No**

If YES: Name _____ **X-Rays Taken:** ☐ **Yes** ☐ **No**

Date of Last Treatment: _____/_____/_____ **(MM/DD/YY)** **Results:** ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

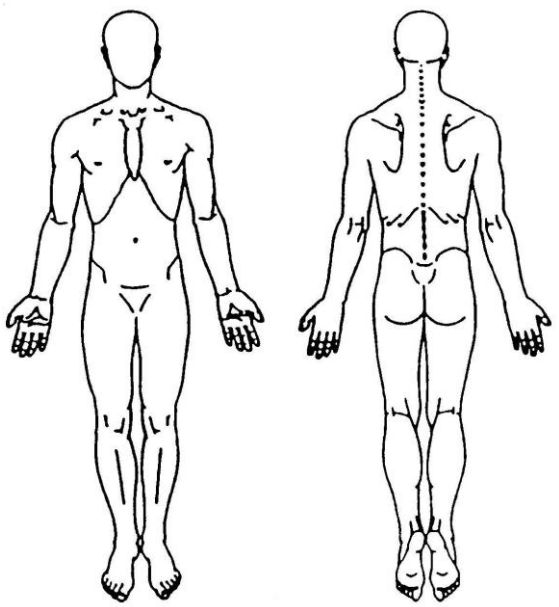
CURRENT HEALTH HISTORY

Reason(s) for consulting this office / Current Complaints:_____

_____

Goals of seeking therapy: _____

On the drawings to the right, mark all painful areas with an X



Describe the pain:

☐ **Sharp & Stabbing** ☐ **Burning** ☐ **Pins & Needles**
☐ **Dull Ache** ☐ **Numb** ☐ **Stiff & Tight**

Please check those activities below during which you experience difficulty or pain:

☐ **Laying on back** ☐ **Dressing self** ☐ **Reaching**
☐ **Standing** ☐ **Sitting** ☐ **Sleeping**
☐ **Laying on side** ☐ **Walking** ☐ **Coughing**
☐ **Sneezing** ☐ **Pushing** ☐ **Pulling**
☐ **Stooping** ☐ **Bending Forward** ☐ **Bending Backward**
☐ **Other**_____

Rate the following by circling a number:

Level of **Pain Now**	None	0	1	2	3	4	5	6	7	8	9	10	**Worst**
Level of **Pain at its worst**	None	0	1	2	3	4	5	6	7	8	9	10	**Worst**
General level of **Stress**	None	0	1	2	3	4	5	6	7	8	9	10	**Severe**
Level of **Physical activity**	None	0	1	2	3	4	5	6	7	8	9	10	**Very active**

PAST HEALTH HISTORY

Have you ever had / or do you currently suffer from any of the following:

☐ **Cardiovascular** ☐ **Ear, Eyes, Nose & Throat** ☐ **Gastrointestinal Problems** ☐ **Genital Urination**
☐ **Low Blood Pressure** ☐ **Ear Aches** ☐ **Nausea** ☐ **Frequent Urination**
☐ **High Blood Pressure** ☐ **Ear Infection** ☐ **Hepatitis** ☐ **Kidney Infection**
☐ **Heart Disease** ☐ **Sinus Infections** ☐ **Muscle & Joint Problems** ☐ **Respiratory Conditions**
☐ **Heart Condition** ☐ **Sore Throat** ☐ **Arthritis** ☐ **Asthma**
☐ **Strokes** ☐ **Vision Problems** ☐ **Neck Pain** ☐ **Pneumonia**
☐ **Bruise Easily** ☐ **Skin** ☐ **Low Back Pain** ☐ **Pleurisy**
☐ **Aneurysm** ☐ **Psoriasis** ☐ **Hernia**

☐ **Osteoporosis** ☐ **Loss of Weight** ☐ **Anxiety** ☐ **Depression** ☐ **Dizziness** ☐ **HIV**
☐ **Epilepsy** ☐ **Fatigue** ☐ **Nerves** ☐ **Headaches** ☐ **Cancer** ☐ **VD**
☐ **Diabetes** ☐ **Fainting** ☐ **Sleeping Difficulty** ☐ **Allergies** ☐ **Polio**

Childhood conditions had:

☐ **Chicken Pox** ☐ **Scarlet Fever** ☐ **Diphtheria** ☐ **Ear Infections** ☐ **Typhoid fever**
☐ **Chronic illness** ☐ **Whooping cough** ☐ **Measles** ☐ **Tubes in ears** ☐ **Rheumatic fever**
☐ **Mumps** ☐**Other:** _____

>>> FOR WOMEN ONLY <<<

Menopausal: ☐ **YES** ☐ **NO** **Are you taking the Birth Control Pill:** ☐ **YES** ☐ **NO**
Last menstrual period: _____/_____/_____ **(MM/DD/YY)**

Regarding your Menstrual Cycle: **Are you currently pregnant:** ☐ **YES** ☐ **NO**
Painful: ☐ **YES** ☐ **NO** **Due Date:** _____/_____/_____ **(MM/DD/YY)**
Heavy: ☐ **YES** ☐ **NO**
Irregular: ☐ **YES** ☐ **NO** **Other:** _____

LIFESTYLE AND HABITS

Do you smoke: ☐ YES ☐ NO **Do you exercise:** ☐ YES ☐ NO **Do you consume alcohol:** ☐ YES ☐ NO

How many hours do you sleep per night: ☐ 4-6 ☐ 6-8 ☐ 8-10 ☐ 12 + **Do you wake rested:** ☐ YES ☐ NO

Do you eat regularly: ☐ Breakfast ☐ Lunch ☐ Dinner

How many meals do you have a day: ☐ One ☐ Two ☐ Three ☐ Four ☐ More than four

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

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

Date of last Dental Examination: _____/_____/_____ **(MM/DD/YY)**

Are you taking any medications (if yes please list): _____

_____

List any supplements you are currently taking: _____

Please list any significant falls and/or accidents: _____

_____

Please list any previous surgeries (and dates they were performed): _____

_____

Hospitalizations: _____

FAMILY HEALTH HISTORY

Have you or anyone in your family had any of the following (<u>please specify whom</u>):

☐ **Heart Disease:** _____ ☐ **High Blood Pressure:** _____

☐ **Cancer:** _____ ☐ **Stroke:** _____

☐ **Diabetes:** _____ ☐ **Other:** _____

FINANCIAL INFORMATION

Payment in full is expected as treatment is rendered. If you are interested in pre-paid packages please speak with one of our staff. Our office accepts Cash, Cheque, Interac, VISA and Mastercard.

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide in our office. We will direct bill your benefit company whenever possible. You are responsible to settle your account with our office. We will gladly supply you detailed receipts for you to submit to your insurance company for reimbursement.

Patients Signature: _____ **Date:** _____/_____/_____ **(MM/DD/YY)**

PRIVACY POLICY

Our Privacy Policy is in accordance with the Personal Information Protection and Electronic Documents Act. A detailed copy of our privacy policy can be made available upon request.

AFTER YOUR VISIT

Treatment Follow-Up:

Permission to leave message □ YES □ NO

Appointment Reminder Calls/Cards :

Permission to leave message/mail/email □ YES □ NO

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