



Date: _____

CONFIDENTIAL PATIENT HEALTH RECORD - ADULT

PERSONAL INFORMATION

Name _____ Address _____
 City _____ Province _____ Postal Code _____
 Home phone _____ Birthdate _____ Gender M _____ F _____
 Business/Employer _____ Type of work _____
 Business phone _____ Email Address _____
 Emergency contact _____ Phone _____ Relationship _____
 Married / Single / Divorced? _____ Spouse's Name _____
 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 have been present for years or decades. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to our health potential.

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	<input type="radio"/> <input type="radio"/> <input type="radio"/>
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		Were you delivered: Naturally <input type="radio"/> C-Section <input type="radio"/> Forceps <input type="radio"/>	
as a child?	<input type="radio"/> <input type="radio"/> <input type="radio"/>	Vacuum <input type="radio"/> Mom induced <input type="radio"/> Unsure <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"/>	On a scale of 1-10 rate your stress level (1 - none, 10 - severe)	
Have you had any surgery?	<input type="radio"/> <input type="radio"/>	Occupational Stress _____ Personal Stress _____	
For what? _____			

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 Liesure

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 and health conditions or concerns they may have:

Children: _____

Spouse: _____

Mother / Father: _____

Brother(s) / Sister(s): _____

Others: _____

Patient Signature _____ ***Date*** _____