New Patient Health History

Please fill out this form to help us focus on your unique history and symptoms and patterns. All answers are confidential. If you have any questions, please feel free to ask.

Date: _____

Name: _____ Address:_____

City: _____Province:_____Postal Code:_____

Home Ph:_____Business Ph:_____Email address:_____

Sex: ☐ M ☐ F Birth: dd/mm/yy_____/_____/_____ Age:_____ height:_____ weight: _____

Bus. Employer/Occupation: _____ Type of Work: _____ Marital Status:_____

Spouse's Name:_____ Children's Name: _____

Alberta Health Care Number:_____ S.I.N. _____

If we need to contact you, messages can be left as (check all that apply): ☐ work ☐ home ☐ e-mail

Would you like to receive our clinic newsletter via e-mail? (yes/no)

How did you hear about our clinic? _____ Referred to this office by:_____

Emergency Contact (if different): _____ Phone:_____

CONFIDENTIAL PATIENT HEALTH RECORD

CURRENT HEALTH CONDITION

Purpose of This Appointment:_____

Major Complaint: _____

Other Doctor's Seen For This Condition: _____

When Did This Condition Begin: _____

Are There Others in Your Family With this Same or Similar Condition: _____

Is This a Worker's Compensation Claim? Yes ____ No ____

Is This an Auto Accident Case? Yes ____ No ____

Medication(s) You Are Taking Now: _____
(Nerve Pills, Pain Killers/Muscle Relaxers, Blood Pressure, Insulin, Aspirin etc.)

Do You Suffer From Any Condition Other Than That Which You Are Now Consulting Us?_____

_____

PAST HEALTH HISTORY

Major Surgery/Operations: ____Appendix ____Tonsils ____Gall Bladder ____Hernia ____Heart ____Back
____Neck ____Leg ____Other _____

Major Accidents or Falls (even as a child) _____

_____

Hospitalization Other Than Above: _____

_____

Previous Chiropractic Care: Doctor's Name and Approximate Date of Last Visit: _____

_____

Date of Last Spine X-Rayed: _____

Have You Been Treated For Any Health Condition in the Last Year: ____Yes ____No

If Yes, Please Explain: _____

Does Anyone Else in Your Family Have the Same or Similar Condition: _____

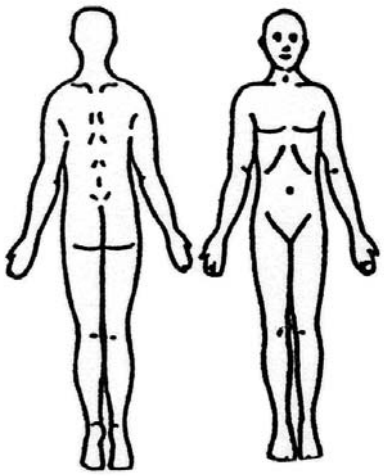
_____

Below are a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan and possibly of being accepted for care:

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD: (Present is in the last 6 months and past is more than 6 months)

	Present	Past		Present	Past		Present	Past		Present	Past
Pneumonia	___	___	Measles	___	___	Heart Disease	___	___	Psychological	___	___
Rheumatic Fever	___	___	Mumps	___	___	Thyroid	___	___	Lumbago	___	___
Polio	___	___	Small Pox	___	___	Influenza	___	___	Eczema	___	___
Tuberculosis	___	___	Chicken Pox	___	___	Pleurisy	___	___	Venereal Infection	___	___
Whooping Cough	___	___	Diabetes	___	___	Arthritis	___	___	A.I.D.S.	___	___
Anemia	___	___	Cancer	___	___	Epilepsy	___	___			

PLEASE OUTLINE ON THE DIAGRAM BELOW THE AREA(S) OF YOUR DISCOMFORT



CHECK ANY OF THE FOLLOWING SPECIFIC CONDITIONS YOU HAVE HAD: (Present is in the last 6 months and past is more than 6 months)

CARDIO-VASCULAR	Present	Past
Chest Pain	___	___
Short Breath	___	___
Blood Pressure Problems	___	___
Irregular Heartbeat	___	___
Heart Problems	___	___
Lung Problems/Congestion	___	___
Varicose Veins	___	___
Ankle Swelling	___	___
Stroke	___	___

GENITO-URINARY		
Bladder Trouble	___	___
Painful/Excessive Urination	___	___
Discolored Urine	___	___

EYE-EAR-NOSE-THROAT	Present	Past
Vision Problems	___	___
Dental Problems	___	___
Sore Throat	___	___
Ear Aches	___	___
Hearing Difficulty	___	___
Stuffed Nose	___	___

GENERAL		
Fatigue	___	___
Allergies	___	___
Loss of Sleep	___	___
Fever	___	___
Headache	___	___

MUSCULO-SKELETAL	Present	Past
Low Back Pain	___	___
Pain Between Shoulders	___	___
Neck Pain	___	___
Arm Pain	___	___
Joint Pain/Stiffness	___	___
Walking Problems	___	___
Difficult Chewing/ Clicking Jaw	___	___
General Stiffness	___	___
Gas/Bloating After Meals	___	___
Heartburn	___	___
Black/Bloody Stool	___	___
Colitis	___	___

NERVOUS SYSTEM	Present	Past
Nervous	___	___
Numbness	___	___
Paralysis	___	___
Dizziness	___	___
Cold/Tingling Extremities	___	___
Forgetfulness	___	___
Confusion/Depression	___	___
Fainting	___	___
Convulsions	___	___
Stress	___	___

HABITS

Smoking ____ # of packs per day ____

Drinking ____ amount of alcohol per week ____

GASTRO-INTESTINAL	Present	Past
Poor/Excessive Appetite	___	___
Excessive Thirst	___	___
Frequent Nausea	___	___
Vomiting	___	___
Diarrhea	___	___
Constipation	___	___
Hemorrhoids	___	___
Liver Problems	___	___
Gall Bladder Problems	___	___
Weight Trouble	___	___
Abdominal Cramps	___	___

EXERCISE

None ____

Moderate ____

Daily ____

MALE/FEMALE	Present	Past
Prostate/Sexual Dysfunction	___	___
Breast Pain/Lumps	___	___
Menstrual Irregularity	___	___
Menstrual Cramping	___	___
Vaginal Pain/Infections	___	___

FEMALES ONLY

When was your least period? Day _____ Month _____ Year _____

Are You Pregnant _____ Yes _____ No _____ Not Sure _____

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother	___	___	___	___	___
Father	___	___	___	___	___
Brother	___	___	___	___	___
Sister	___	___	___	___	___

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic Care (Preventive Care). These are the three types of care. Your doctor will weigh your needs and desires when recommending your schedule of care. Please check the type of care desired so that we may be guided by your wishes whenever possible.

____ Relief Care ____ Corrective Care ____ Preventive Care

CANCELLATION POLICY

A minimum of 24 hours notice is required in case of cancellation. Otherwise, the full fee for the visit will be charged.

_____ _____

DATE **PATIENT'S SIGNATURE**