

HEALTH HISTORY FORM



Today's Date: _____ Who may we thank for this referral ? _____

Full Name: _____ Preferred First Name: _____

Street Address: _____

City: _____ Province: _____ Postal Code: _____

Home phone: _____ Cellular: _____ Work: _____

Age: _____ Birthdate: (M)____/(D)____/(Y)____ Care Card # _____

Marital Status: _____ Spouse Name: _____

of Children: _____ their names and ages: _____

Occupation: _____ Employer: _____

Patient ID #

Primary Email (to notify you of health education events taking place at our clinic): _____

THE PURPOSE OF MY VISIT

- Symptom relief and preventing its return.
- 100% optimum health and wellbeing on every level available to me.
- My commitment level to optimal health is (please rate from 0 to 10) : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

CHIROPRACTIC HISTORY

Have you been to a chiropractor before? Yes/No Name of previous chiropractor: _____

How long were you under care? _____ What were the results? _____

ICBC – CAR ACCIDENTS

Have you been in a car accident in the last 12 months ? Yes/No If yes: Accident Date: _____

Do you have an open claim with ICBC for this accident ? Yes/No If yes, ICBC Claim #: _____

Have you seen a chiropractor for this claim ? Yes/No If yes, chiropractor's name _____

YOUR MEDICAL HISTORY Please check any of the following conditions currently or recently experienced:

- | | | |
|---|---|--|
| <input type="checkbox"/> Head Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Hearing / Ear Problems: Left / Right | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Weight Problems |
| <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Thyroid Problems: Underactive / Overactive | <input type="checkbox"/> Alcohol / Substance Challenges |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Blood Pressure Problems: Low / High |
| <input type="checkbox"/> Shoulder Pain: Left / Right | <input type="checkbox"/> Heartburn | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Arm Pain: Left / Right | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Heart Problems: _____ |
| <input type="checkbox"/> Hand/Wrist Pain: Left / Right | <input type="checkbox"/> Stomach / Digestive Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Carpal Tunnel Syndrome: Left / Right | <input type="checkbox"/> Constipation: _____ | <input type="checkbox"/> Diabetes: Type 1 / Type 2 |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Aids/ HIV |
| <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Recurrent Infections: |
| <input type="checkbox"/> Rib Pain: Left / Right | <input type="checkbox"/> Immune Function Problems | ___ Ear |
| <input type="checkbox"/> Hip Pain: Left / Right | <input type="checkbox"/> Chronic Fatigue/Fibromyalgia | ___ Sore Throat |
| <input type="checkbox"/> Disc Herniation | <input type="checkbox"/> Skin Problems | ___ Respiratory/Colds |
| <input type="checkbox"/> Sciatica: Left / Right | <input type="checkbox"/> Allergies: _____ | ___ Bladder Infections |
| <input type="checkbox"/> Knee Pain: Left / Right | <input type="checkbox"/> Gout | ___ Yeast Infections |
| <input type="checkbox"/> Ankle Pain: Left / Right | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Family History: diabetes / cancer / |
| <input type="checkbox"/> Menstrual Pain / Irregularity | <input type="checkbox"/> Fertility Problems | heart disease / other family related illness |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Sexual Functioning Problems | <input type="checkbox"/> Other conditions: _____ |
| | <input type="checkbox"/> Low Energy | _____ |

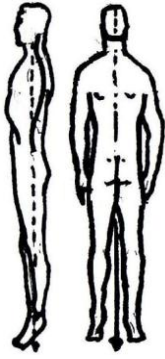
MAJOR HEALTH CONCERNS Please identify 3 major health concerns you are currently experiencing.
On a scale of **0** to **10**, with **zero** being no pain and **10** being the worst pain, rate your concerns by **circling the number** :

Problem # 1 _____ : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
 When did the problem begin? _____ How did the problem begin? _____
 Is it : Getting better Getting worse Staying the same
 Pains are : Dull Ache Tightness Throbbing Spasm Numb Sharp Burning Shooting
 How long does it last ? It's constant I experience it on and off during the day It comes and goes through the week
 What activities aggravate this problem ? Please describe: _____
 Is there anything that relieves your symptoms ? No If yes, please describe: _____

Problem # 2 _____ : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
 When did the problem begin? _____ How did the problem begin? _____
 Is it : Getting better Getting worse Staying the same
 Pains are : Sharp Dull Ache Burning Tightness Throbbing Spasm Numb Shooting
 How long does it last ? It's constant I experience it on and off during the day It comes and goes through the week
 What activities aggravate this problem ? Please describe: _____
 Is there anything that relieves your symptoms ? No If yes, please describe: _____

Problem # 3 _____ : 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
 When did the problem begin? _____ How did the problem begin? _____
 Is it : Getting better Getting worse Staying the same
 Pains are : Sharp Dull Ache Burning Tightness Throbbing Spasm Numb Shooting
 How long does it last ? It's constant I experience it on and off during the day It comes and goes through the week
 What activities aggravate this problem ? Please describe: _____
 Is there anything that relieves your symptoms ? No If yes, please describe: _____

FOR OFFICE USE ONLY



Leg Length
D _ D _

Weight

C1
C2
C3
C4
C5
C6
C7
T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12
L1
L2
L3
L4
L5
S1
C

Rx Meds :

Sx :

Fx :

MVA's :

Work Related Injuries :


Sports / Rec Injuries :

Injuries at Home :

Injuries at Birth / Childhood :

Patient's body signals for conditions checked off in Medical History section :

Cervical **Lumbar**



C/Sp _____ cm L/Sp _____ cm F/Sp _____ cm

Clinical Implications

VSC CTLs
 Assoc Muscle Dysfunction
 Advanced Arthritis
 Other _____

Plan of Managements

Corrective Adjustments
 Spinal Exercise
 Nutritional
 Other _____