CONFIDENTIAL PATIENT HEALTH RECORD

Personal History

Dear Patient:
Please complete this questionnaire. Your answers will help us determine if chiropractic can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name: ____ Date: ____________________

Address: ___________________________________ City: _______________________ Prov: __________

Postal Code: _____________ Home Phone: _____________ Work Phone: __________ Cellular: ____________

Email Address: ________________________________ **Subscribe** ☐ (consent to receive email reminders, newsletters)

☐ **Unsubscribe** (do not want to receive any communication)

Birth date: Month ____________Day ____________ Year ____________ Age: ____________

Marital Status: Single ☐ Married ☐ Common law ☐ Separated ☐ Divorced ☐ Widowed ☐

Number of Children: _________ Ages: ____________________

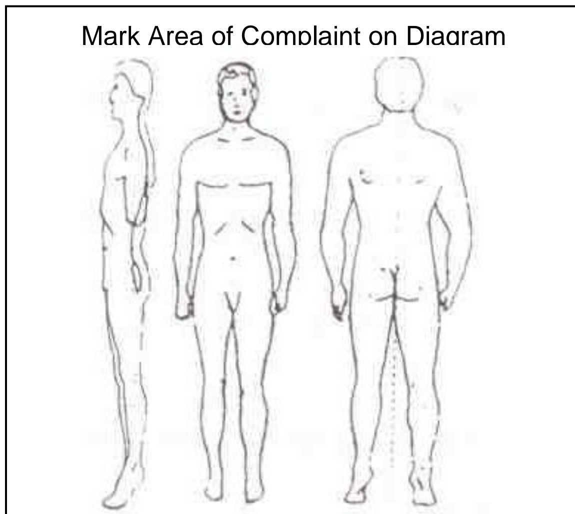
Type of Work: _______________________________

Who can we thank for referring you to our office: ____

Who is responsible for your bill? Private ☐ WCB ☐ ICBC ☐ RCMP ☐ DVA ☐
Do you have extended health? Yes ☐ No ☐

CURRENT HEALTH CONDITION

Mark Area of Complaint on Diagram



Purpose of this appointment ______________________________
____

Secondary complaint(s) ________________________________
____

Other practitioners seen for this condition? ________________
____

When did this condition begin? __________________________
Is this condition becoming worse? Yes ☐ No ☐ Varies ☐

Medications being taken: None ☐ Nerve pills ☐ Pain killers ☐ Muscle relaxants ☐ Blood pressure ☐ Aspirin ☐ Thyroid ☐ Anti-inflammatory ☐ Insulin/diabetic material ☐ Birth control pills ☐ Other ☐_______________

Major Surgeries: Gall bladder ☐ Heart ☐ Back ☐ Neck ☐ Hernia ☐ Hysterectomy ☐
Other ☐____

Are there any other health conditions that we should be aware of? ____

How long has it been since you really felt good? ____

Do you wear heel lifts? Yes ☐ No ☐ Orthotics? Yes ☐ No ☐

Females Only:
Are you pregnant? Yes ☐ No ☐ Not sure ☐
Date of last period ______________________

Intake	Amount/Day
☐ Coffee	________
☐ Tea	________
☐ Alcohol	________
☐ Cigarettes	________

Have you had previous chiropractic care? Yes ☐ No ☐ If yes, when did your care begin? ____________________

Length of time under care? _____________________When were you last adjusted?______________________________

Name of chiropractor? _____________________________Were x-rays taken? ________________ Date? ___________

Research is showing that many of the health challenges that occur later in life have their origins during the early years, some starting at birth. Please list even minor accidents or traumas.

Auto accidents: ____

Fall / injuries: ____

WCB injuries: ____

Childhood / birth traumas: ____

Sports injuries: ____

Have you ever had any broken bones? ☐ No ☐ Yes Details: ____

Have you ever had a concussion? ☐ No ☐ Yes Details: ____

Do you have allergies? ☐ No ☐ Yes List: ____

Do you regularly exercise? ☐ No ☐ Yes Days per weeks? ________________________________

Do you sleep well? ☐ No ☐ Yes How many hours? ________________________________

Do you eat a healthy diet? ☐ No ☐ Yes

Do you take vitamins? ☐ No ☐ Yes List: ____

We want to provide you with the best possible health care. To do this we will first need to understand what you want to achieve. Please mark the statement that most clearly reflects your health care objectives:

☐ Wellness: I want to build my inner strength. I am conscious about my health, diet, exercise, etc. and actively pursue these because I feel better and it maximizes my potential.

☐ Treatment only: I only consult a health care practitioner when I have an ache or pain and discontinue care when it subsides.

I believe my commitment to health is: Important 1 2 3 4 5 6 7 8 9 10 Utmost Importance

If you could pick one outcome from your chiropractic care, what would it be? ____________________________________

PATIENT – DOCTOR AGREEMENT

New Patient $80.00 **SEMG** $10

Regular Visit $55.00 Adults
$45.00 Children
$50.00 Student & Seniors (over 65 yrs.)

All patients pay our regular office fees. However, the Medical Services Plan reimburses $23.00 per visit up to 10 visits per year to **individuals receiving premium assistance**. These visits are inclusive of treatments by chiropractors, massage therapists, naturopaths, physiotherapists, and podiatrists. If you qualify for premium assistance our office will submit to Medical Services Plan, on your behalf, and you will receive your reimbursement through the mail in four to six weeks. Submission to extended health plans is the patient’s responsibility, receipts given upon request.

PAYMENT IS DUE AT TIME SERVICES RENDERED

I UNDERSTAND AND AGREE TO THE FEE POLICY WITHIN THIS OFFICE. I ALSO UNDERSTAND THAT FEES ARE DUE WHEN SERVICES ARE RENDERED AND THAT I AM RESPONSIBLE FOR PAYMENT.

Patient’s Signature ____ Date ______________________

Have you ever been diagnosed with the following?

- ☐ Alcoholism
- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Stomach ulcer
- ☐ Polio
- ☐ High blood pressure
- ☐ Irritable bowel / colitis
- ☐ Diabetes
- ☐ Anemia
- ☐ Heart disease
- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Cancer
- ☐ Thyroid problems
- ☐ Eczema / skin condition
- ☐ Arthritis (osteo, rheumatoid)
- ☐ Asthma
- ☐ Arteriosclerosis
- ☐ Stroke
- ☐ Crohn's disease
- ☐ Seizures

Have any of the following occurred? **P** = previously **C** = currently

P	C	
☐	☐	Depression
☐	☐	Death in family
☐	☐	Anxiety
☐	☐	Chronic fatigue
☐	☐	Weight loss/gain
☐	☐	Divorce
☐	☐	Change in job status
☐	☐	Increased work stress
☐	☐	Family problems
☐	☐	Nervousness
☐	☐	Mood Swings
☐	☐	Drug / alcohol over use
☐	☐	Sleeping problems
☐	☐	Economic stress
☐	☐	Tension
☐	☐	Other _________________

Family Health Information:
Many health problems are the result of hereditary spinal weakness. Thus, information about your family members will give us a better picture of your total health. Please list any member of your family who has <u>any</u> kind of health problem.

Name Relation Problem
____

____

Please check (4) all symptoms which apply to you, even if they do not seem related to your current problem.
P = Previously (over 1 year ago) **C** = Currently (during last year)

P	C	
☐	☐	Headaches
☐	☐	Migraines
☐	☐	Neck stiffness / pain
☐	☐	Arm or shoulder pain
☐	☐	Elbow / hand pain
☐	☐	Pain between shoulders
☐	☐	Cold hands / feet
☐	☐	Back pain / stiffness
☐	☐	Difficulty walking
☐	☐	Leg pain
☐	☐	Foot / ankle pain
☐	☐	Knee Pain
☐	☐	Hip pain
☐	☐	Wheezing
☐	☐	Chest pain
☐	☐	Irregular heart beats
☐	☐	Lung problem / congestion
☐	☐	Dizziness / loss of balance
☐	☐	Frequent nausea
☐	☐	Loss of smell / taste
☐	☐	Buzzing / ringing in ears
☐	☐	Fainting
☐	☐	Cold Sweats
☐	☐	Fever
☐	☐	Vomiting
☐	☐	Irritability
☐	☐	Incontinence
☐	☐	Urinary / bladder problems
☐	☐	Painful urination
☐	☐	Colitis
☐	☐	Earaches or infections
☐	☐	Hearing difficulty
☐	☐	Stuffed nose due to allergies
☐	☐	Other sinus problems
☐	☐	Gas / bloating
☐	☐	Stomach problems
☐	☐	Heartburn
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Hemorrhoids
☐	☐	Blood in stools
☐	☐	Liver problems
☐	☐	Gall bladder problems
☐	☐	Prostate dysfunction
☐	☐	Sexual dysfunction / pain
☐	☐	Hot flashes
☐	☐	Menstrual pain / cramping
☐	☐	Menstrual irregularity

Numbness or Tingling In

P	C	
☐	☐	Shoulders
☐	☐	Arms
☐	☐	Elbows
☐	☐	Hands
☐	☐	Knees
☐	☐	Feet
☐	☐	Hips
☐	☐	Legs

In what position do you sleep?

☐ Side ☐ Front ☐ Back

Patient's Signature: ____ Date ____________________

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