HEALTH HISTORY FORM

Today's Date: _____

How did you hear about the clinic?
☐Referral: _____
☐Internet ☐Radio ☐Live in the area

PATIENT DEMOGRAPHICS

Name: _____
Address: _____
Home Phone #: _____
Mobile Phone #: _____
Work Phone #: _____
Occupation: _____How many years:_____
Employer: _____

Birth Date: Day____ Month____ Year____ Age:____ ☐ Male ☐ Female
City:_____Province:_____Postal Code: _____
E-mail Address: _____
Are you in school? ☐ Yes ☐ No. If so: ☐F/T or ☐P/T
(If yes) Name of School: _____
Name of spouse: _____
Names & Ages of children:_____

MPI/WCB

Will you be claiming: Autopac (MPI): Y/N Worker's Compensation: Y/N
If yes: Injury/Accident Date: _____ Personal Injury Claim #: _____
How many people were in the vehicle? :_____

CHIROPRACTIC HISTORY

Have you been to a chiropractor before? Y/N Name of previous chiropractor: _____
How long were you under care?:_____ What were the results?:_____

HEALTH GOALS

Please check all that apply:

- ❑ Be pain free.
- ❑ To not have to take medication anymore.
- ❑ Lose weight. How much? _____
- ❑ Live a long, healthy life.
- ❑ Other: _____

SYMPTOMS

Please check all that you have experienced in the last 6 months:

- ❑ Headaches
- ❑ Migraines
- ❑ Neck Pain
- ❑ Shoulder Pain
- ❑ Upper Back Pain
- ❑ Hand/Wrist Pain
- ❑ Mid Back Pain
- ❑ Low Back Pain
- ❑ Stomach Pain
- ❑ Rib Pain
- ❑ Hip Pain
- ❑ Knee Pain
- ❑ Ankle Pain
- ❑ Chest Pain
- ❑ Sinus Problems
- ❑ Ear Infections
- ❑ Ringing in Ears
- ❑ Jaw Problems
- ❑ Asthma
- ❑ Heartburn
- ❑ Carpal Tunnel Syndrome
- ❑ Allergies
- ❑ Constipation
- ❑ Diarrhea
- ❑ Menstrual Cramps
- ❑ Ulcers
- ❑ Arthritis
- ❑ Gout
- ❑ Fatigue
- ❑ Decreased Energy
- ❑ Difficulty Breathing
- ❑ Difficulty Sleeping
- ❑ Hot Flashes
- ❑ Jaundice
- ❑ Anxiety
- ❑ Depression
- ❑ Thyroid Condition
- ❑ Diabetes
- ❑ Cancer
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Heart Disease
- ❑ Stroke
- ❑ Dizziness
- ❑ Other: _____

PLEASE EXPLAIN YOUR CONDITIONS ON THE SECOND PAGE →

OFFICE USE ONLY
ID:_____
Type of Patient:
- ☐ **Corporate Wellness:** _____
- ☐ **Whoelse Patient**
- ☐ **Metro Marketing Patient**
- ☐ **MPI Patient**
- ☐ **WCB Patient**
- ☐ **Massage**
- ☐ **Old New Patient (Walk-in / Reactivated)**
  Last Visit:_____

- ☐ **Regular New Patient**
  Insurance Coverage:_____
  - ☐ **Signed INS Forms**
  - ☐ **Signed Credit Form**
- ☐ **Free Consultation**
- ☐ **Dr. Gil**
- ☐ **Dr. Tracy**
- ☐ **Dr. Daniel**
- ☐ **Dr. Steven**
- ☐ **Dr. Nicole**
- ☐ **Dr. Glenn**

Notes:

PLEASE PROCEED TO SECOND PAGE

What are the 3 problems you want the doctor to know more about?

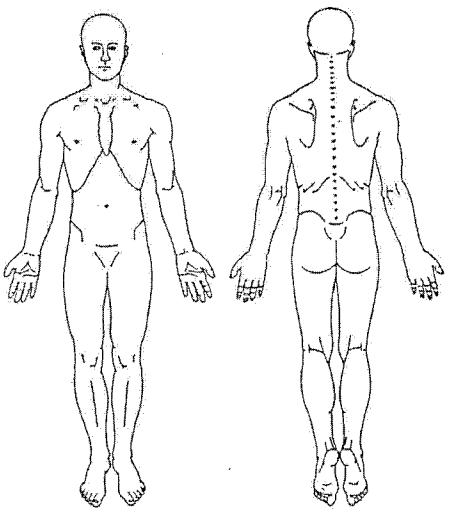
On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number***:

Problem 1._____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the problem(s) begin?_____How did the problem(s) begin? _____
Is the pain: ☐ Getting better ☐ Getting worse ☐ Staying the same
How often do you feel the problem? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:_____
How many hours in a day do you feel pain? ☐ 1hour ☐ 4hours ☐ 6hours ☐ 8hours ☐ 12hours ☐ Constant ☐ Other
Have you ever had the problem before? _____
What makes the pain better? _____
What makes the pain worse? _____
Describe the pain: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Shooting ☐ Numb ☐ Other: _____
Is there anything else the doctor needs to know about this condition? _____

Problem 2._____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the problem(s) begin?_____How did the problem(s) begin? _____
Is the pain: ☐ Getting better ☐ Getting worse ☐ Staying the same
How often do you feel the problem? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:_____
How many hours in a day do you feel pain? ☐ 1hour ☐ 4hours ☐ 6hours ☐ 8hours ☐ 12hours ☐ Constant ☐ Other
Have you ever had the problem before? _____
What makes the pain better? _____
What makes the pain worse? _____
Describe the pain: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Shooting ☐ Numb ☐ Other: _____
Is there anything else the doctor needs to know about this condition? _____

Problem 3._____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the problem(s) begin?_____How did the problem(s) begin? _____
Is the pain: ☐ Getting better ☐ Getting worse ☐ Staying the same
How often do you feel the problem? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:_____
How many hours in a day do you feel pain? ☐ 1hour ☐ 4hours ☐ 6hours ☐ 8hours ☐ 12hours ☐ Constant ☐ Other
Have you ever had the problem before? _____
What makes the pain better? _____
What makes the pain worse? _____
Describe the pain: ☐ Sharp ☐ Dull ☐ Stabbing ☐ Shooting ☐ Numb ☐ Other: _____
Is there anything else the doctor needs to know about this condition? _____

***MARK 'X'** anywhere you feel pain:



PLEASE PROCEED TO THIRD PAGE

FAMILIAL HISTORY

Do you have a family history of the following diseases? If so please write down who & how old they are.

❑Cancer: _____

❑ Heart Disease: _____

❑ Diabetes: _____

❑ Other: _____

❑ None

PAST ACCIDENT/TRAUMA/INJURY HISTORY

Have you ever had x-rays taken? ❑ Yes ❑ No If yes, of what? _____

How many car accidents have you been in?_____Dates: _____

Any work, sports, or other injuries? Please describe: _____

_____

_____

Any concussions?_____

_____

PAST SURGICAL HISTORY

Please list any prior surgeries you have had and dates_____

_____

_____

LIFESTYLE

Do you smoke? ❑ Yes ❑ No How many per day? _____

Do you drink alcohol? ❑ Yes ❑ No How many per week? _____

Do you drink coffee, tea or soda? ❑ Yes ❑ No How many per week? _____

Do you exercise regularly? ❑ Yes ❑ No How many times per week? _____

MEDICATIONS

Who is your medical doctor? _____

Please list all medications you are taking. How long have you been taking these medications?

_____How long? _____

_____How long? _____

_____How long? _____

_____How long? _____

_____How long? _____

What vitamins, minerals, or herbs do you currently take?

_____

_____

WOMEN'S HEALTH

Are you pregnant? ❑ Yes ❑ No If yes, how far long? _____

Are you nursing? ❑ Yes ❑ No

Are you taking birth control medication (pill, injection, other)? ❑ Yes ❑ No