

Chiropractic - Adult

File #: \_\_\_\_\_

Date: \_\_\_\_\_



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## General Information

### How do you wish to be addressed in our office?

First name       Mr.       Mrs.       Miss       Ms.       Dr.

### How do you wish to be contacted by our office regarding your appointments?

Email       Phone

Last Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

First Name: \_\_\_\_\_ Sex:     M     F

Address: \_\_\_\_\_

Town/City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_

Email: \_\_\_\_\_ Please Initial Consent to receive email communication from the clinic

Occupation: \_\_\_\_\_ Spouse's name (if applicable): \_\_\_\_\_

Children:    Y    N    Number: \_\_\_\_\_ Ages: \_\_\_\_\_

(Females) Are you pregnant?    Y    N    How many weeks? \_\_\_\_\_ Estimated Due Date: \_\_\_\_\_

Family Dr. Name: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

### Previous Wellness Care? (check all that apply)

Chiropractic       Physiotherapy       Naturopathy       Massage Therapy       Osteopathy

Location: \_\_\_\_\_

Referred by: \_\_\_\_\_

How did you decide to choose our office? \_\_\_\_\_

### Reason for consulting the office:

- I have a specific problem and require help only with this problem.
- After my specific problem has been relieved, I am interested in strategies for maintenance.
- After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.
- I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

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## Health History

The following health history is designed to uncover all areas of ill health. As the human body is designed to be healthy, any deviation from optimal health will reduce your body's wellness potential. A detailed history can give your chiropractor valuable insight into the wellness condition of your body. Your health history includes your journey from childhood to present. Please take the time to **fully complete** this form to the best of your ability:

### A. Growth and Development (Please circle either Y or N)

Y      N      **To your knowledge, were there any difficulties or interventions employed at your birth? (difficult delivery, forceps, vacuum extraction, epidural, c-section)**

**Explain:** \_\_\_\_\_

Y      N      **To your knowledge, did you ever experience a fall (out of bed, off a change table, table etc.) as an infant/toddler?**

**Explain:** \_\_\_\_\_

Y      N      **Childhood Illnesses? Explain** \_\_\_\_\_

Y      N      **Childhood Accidents? (include sports injuries, slips and falls, etc.)**

**Explain:** \_\_\_\_\_

Y      N      **Did you ever play contact sports?**

Y      N      **Have you ever been told you have a scoliosis?**

Y      N      **Any other childhood traumas?**

**Explain:** \_\_\_\_\_

Y      N      **To your best recollection, were you vaccinated as a child?**

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**B. Current Health Status** (Please circle either Y or N)

Y      N      **Have you had any past surgeries? If so, what?** \_\_\_\_\_

Y      N      **Do you smoke?**

Y      N      **Have you smoked in the past? Date quit:** \_\_\_\_\_

Y      N      **Do you drink any alcohol? If so, how much/week?** \_\_\_\_\_

Y      N      **Do you feel that you have an adequate diet, especially vegetables?**

Y      N      **Have you ever been in a motor vehicle collision (include minor ones)?**

**Explain:** \_\_\_\_\_

Y      N      **Have you had any other accidents, trauma or fractures?**

**Explain:** \_\_\_\_\_

Y      N      **Previously diagnosed medical conditions? List:** \_\_\_\_\_

\_\_\_\_\_

Y      N      **Drugs / Prescription / Over the Counter / Recreational / Birth Control**

**If yes, list drug and condition:** \_\_\_\_\_

\_\_\_\_\_

Y      N      **Dental problems?**

Y      N      **Hearing problems?**

Y      N      **Regular Exercise?**                      Aerobic/Non-aerobic                      \_\_\_\_\_ x/Week

**Stress:**              Occupational \_\_\_\_\_              Physical \_\_\_\_\_              Mental \_\_\_\_\_

**Sleeping Posture:**      Back \_\_\_\_\_      Front \_\_\_\_\_      Side \_\_\_\_\_      Hours of Sleep \_\_\_\_\_ /Night

**Have you had any past x-Rays? If so, which?** \_\_\_\_\_

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### C. Health Symptoms

Health symptoms often appear after years of underlying dysfunction. Please briefly describe any current painful symptoms you are experiencing: \_\_\_\_\_  
\_\_\_\_\_

How long ago did the problem start? \_\_\_\_\_

The pain you experience is:    CONSTANT                      INTERMITTENT

What aggravates your pain or problem? \_\_\_\_\_

What relieves your pain or problem? \_\_\_\_\_

Does your pain radiate or travel to other parts of your body?                      Y                      N

Does your condition get worse at certain times of the day or night? \_\_\_\_\_

How long does the pain last when you get the pain? \_\_\_\_\_

Is your condition:                      WORSENING                      IMPROVING

Have you consulted other health professionals regarding this problem?                      Y                      N

If yes, which ones? \_\_\_\_\_

Family History of:    Heart Disease \_\_\_\_\_    Stroke \_\_\_\_\_    Cancer \_\_\_\_\_    Diabetes \_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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### D. Other Symptoms

Please check a box if you currently experience or have experienced any of these in the past:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Numbness in toes     | <input type="checkbox"/> Loss of taste  |
| <input type="checkbox"/> Neck pain              | <input type="checkbox"/> Shortness of breath  | <input type="checkbox"/> Diarrhea   |
| <input type="checkbox"/> Back pain              | <input type="checkbox"/> Fatigue              | <input type="checkbox"/> Stomach upset  |
| <input type="checkbox"/> Sleeping problems      | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Abdominal pain   |
| <input type="checkbox"/> Stress                 | <input type="checkbox"/> Memory loss          | <input type="checkbox"/> Constipation   |
| <input type="checkbox"/> Irritability           | <input type="checkbox"/> Ringing in ears      | <input type="checkbox"/> Cold sweats  |
| <input type="checkbox"/> Chest pains            | <input type="checkbox"/> Ear infections       | <input type="checkbox"/> Fever  |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Heart trouble        | <input type="checkbox"/> Prostate problems  |
| <input type="checkbox"/> Stiff neck             | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Hepatitis B  |
| <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Loss of balance      | <input type="checkbox"/> HIV  |
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Trouble with bowel or bladder control                            |
| <input type="checkbox"/> Numbness in fingers    | <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Reproductive problems (endometriosis, fibroids, impotence, etc.) |
| <input type="checkbox"/> Painful menstruation   | <input type="checkbox"/> Depression           |   |

### Expectations:

Please list your top 3 expectations that you have regarding your care at Waterdown Village Chiropractic & Wellness Group:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_