

# New Patient Health History

In order to provide you the best possible wellness care, please complete this form and bring it to you first appointment. All information is strictly CONFIDENTIAL.

## PATIENT INFORMATION

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ Sex: M F  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
AHC#: \_\_\_\_\_ Single / Married / Separated  
Occupation: \_\_\_\_\_ Divorced / Widowed  
Employer: \_\_\_\_\_  
Parents name (if a minor): \_\_\_\_\_  
What are you seeking?  
 Temporary Relief  Corrective Care  Wellness Care  
*(Get rid of pain) (get rid of cause) (get me well, keep me well)*

## CONTACT INFORMATION

Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
E-mail: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_

## ACCIDENT INFORMATION

Is your condition due to an accident?  YES  NO  
If yes, was it a :  Work/ Sports Accident  Injury  Car Accident  
To whom have you reported the accident?  
 Nobody  Ins. Company  WCB  Employer  Other: \_\_\_\_\_

## REFERRAL INFORMATION

How did you discover our office?  
 Friend/Family Member \_\_\_\_\_  
 Yellow Pages  Sign  Radio  
 Other: \_\_\_\_\_

## CURRENT COMPLAINT

What is your major symptom/complaint? \_\_\_\_\_  
When did your symptoms begin? \_\_\_\_\_ Have you had this complaint before? YES NO  
Is your condition getting:  Better  Worse  Remains (same) Is this complaint:  Constant  Comes and goes  
What makes your condition better? \_\_\_\_\_  
What makes your condition worse? \_\_\_\_\_  
Does it interfere with your  Work  Sleep  Daily Routine  Recreation  Other : \_\_\_\_\_

## MEDICAL HISTORY

Have you been treated for any conditions in the last year?  NO  YES  
If yes, please describe: \_\_\_\_\_  
Date of last physical exam? \_\_\_\_\_ Is there a chance that you are pregnant?  NO  YES  
Have you had a MRI or CT scan done?  YES  NO If yes, where? \_\_\_\_\_  
What medications are you taking and for what conditions (please list dosage and amounts etc): \_\_\_\_\_  
What vitamins, minerals or herbs do you currently take? \_\_\_\_\_  
What kinds of treatments have you received?  
Chiropractic : By who? \_\_\_\_\_ When ? \_\_\_\_\_ Why? \_\_\_\_\_ X-Rays? Yes No  
Medical Dr.: By who? \_\_\_\_\_ When ? \_\_\_\_\_ Why? \_\_\_\_\_ X-Rays? Yes No  
Physiotherapy: By who? \_\_\_\_\_ When ? \_\_\_\_\_ Why? \_\_\_\_\_  
Acupuncture: By who? \_\_\_\_\_ When ? \_\_\_\_\_ Why? \_\_\_\_\_  
Massage: By who? \_\_\_\_\_ When ? \_\_\_\_\_ Why? \_\_\_\_\_  
Other: \_\_\_\_\_

## HAVE YOU EVER...

	NO	YES	Briefly Explain:
Broken Bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been Hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an Auto-accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Sprains/Strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had any Falls?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Work / Sports Injuries?	<input type="checkbox"/>	<input type="checkbox"/>	_____

## FAMILY HISTORY

M - Mother    F - Father    S - Sister    B - Brother    GP - Grandparents, fill in the blanks, any that apply.

_____ High Blood Pressure	_____ Cancer	_____ Anemia	OTHER: _____
_____ Heart Disease	_____ Diabetes	_____ Arthritis	_____
_____ Thyroid Disease	_____ Migranes	_____ Asthma, Emphysema	_____
_____ Kidney Disease	_____ Seizures	_____ Strokes	_____

Mother Living?  YES  NO - explain \_\_\_\_\_

Father Living?  YES  NO - explain \_\_\_\_\_

## HABITS

	None	Light	Moderate	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco/Smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugary Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## SYMPTOM CHARACTERISTICS

1. Do your symptoms interfere with daily life? YES NO
2. Does pain wake you up at night? YES NO
3. Are your symptoms worse during certain times of the day? NO YES - am noon pm night
4. Does the weather affect your symptoms? YES NO
5. Do you wear orthotics? YES NO
6. How often do you experience the pain?  
daily weekly monthly - explain: \_\_\_\_\_

List any other complaints currently bothering you?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## HAVE YOU EVER SUFFERED FROM ...

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Cramps	<input type="checkbox"/> Irregular Heart Beat	<input type="checkbox"/> Poor Posture
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Depression	<input type="checkbox"/> Irregular Cycle	<input type="checkbox"/> Prostate Trouble
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney Infection	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Seizures
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Loss of Coordination	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Aortic Aneurysm	<input type="checkbox"/> Digestion Problems	<input type="checkbox"/> Loss of Memory	<input type="checkbox"/> Sinus Infection
<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Sleep Problems/Insomnia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Ears Ring	<input type="checkbox"/> Loss of Smell	<input type="checkbox"/> Spinal Curvatures
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Loss of Taste	<input type="checkbox"/> STD
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Excessive Menstruation	<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Stroke
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Eye Pain/Difficulties	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Swelling of Ankles
<input type="checkbox"/> Breast Lump	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Neck Pain or Stiffness	<input type="checkbox"/> Swollen Joints
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Gas	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hand Trembling	<input type="checkbox"/> Numbness	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Chest Pain/Conditions	<input type="checkbox"/> Headache	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Chills	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Painful Tailbone	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Pleursy	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Cold Extremities	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> PMS	<input type="checkbox"/> Weakness
<input type="checkbox"/> Colon Problems	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Polio	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Constipation	<input type="checkbox"/> Infertility	<input type="checkbox"/> Poor Appetite	

## GENERAL ACTIVITIES

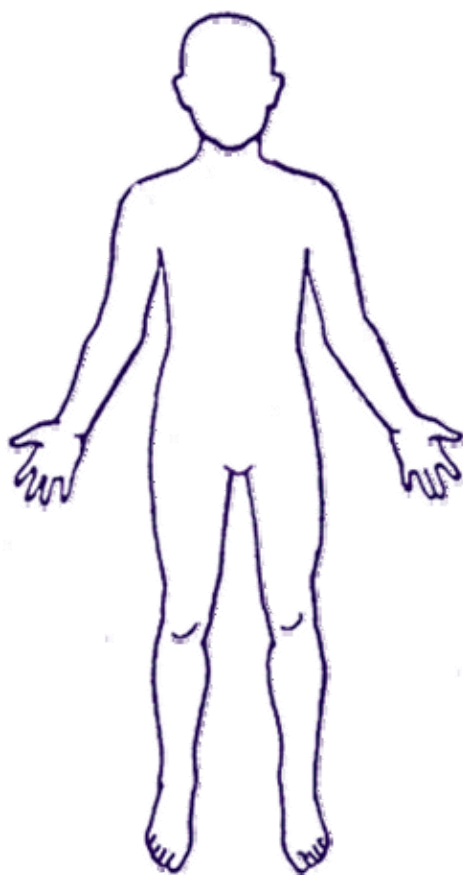
*(check all that apply)*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Sleep on a waterbed    | <input type="checkbox"/> Fall asleep in recliner / on couch    | <input type="checkbox"/> Vacuuming / Snow Shoveling                          |
| <input type="checkbox"/> Sleep on Stomach       | <input type="checkbox"/> Use two or more pillows to sleep with | <input type="checkbox"/> Lifting with back instead of knees                  |
| <input type="checkbox"/> Read in Bed            | <input type="checkbox"/> Play video games ( _____ hrs per day) | <input type="checkbox"/> Heavy Lifting                                       |
| <input type="checkbox"/> Needlepoint / knitting | <input type="checkbox"/> Computer use ( _____ hrs per day)     | <input type="checkbox"/> Long-Distance Driving                               |
| <input type="checkbox"/> Gardening              | <input type="checkbox"/> Watch television ( _____ hrs per day) | <input type="checkbox"/> Cradling phone <i>(between neck &amp; shoulder)</i> |

Please add anything else you would like the doctor to know: \_\_\_\_\_

## LOCATION AND TYPE OF SYMPTOMS

Please use the following letters to indicate **type** and **location** of the symptoms you currently are experiencing.



**N = Numbness**

**P = Pins & Needles**

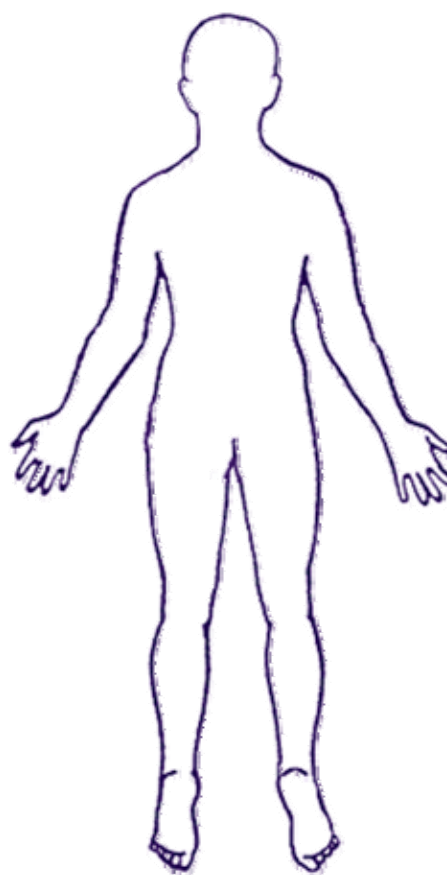
**A = Ache**

**B = Burning**

**S = Stabbing**

**O = Other**

**M = Muscle Tightness**



## AUTHORIZATION

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize this office to release any information including the diagnosis and the records of any treatments or examination rendered to me or my child during the period of such chiropractic care to third party payers and /or health practitioners. I consent to the periodic video and audio recording of my chiropractic treatment for the purpose of accurate record keeping. I authorize and request Alberta Health Care to pay directly to this office benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature: \_\_\_\_\_

*(signature of parent if the patient is a minor)*

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