Snelgrove Chiropractic
Family Wellness Center

CONFIDENTIAL PATIENT HEALTH RECORD

Name:			Email Address:	
Address:			City:	Postal Code:
			Home Phone:	Work Phone:
Age:	Sex: ☐ M ☐ F	Date of Birth: (mm/dd/yy)	Extended Health Insurance ☐ yes ☐ no Details:	
Occupation:		Employer:		
Marital Status: ☐ single ☐ married ☐ widowed ☐ divorced/separated ☐ common-law		Spouse's Name:	Spouse's Occupation:	
Do you have children? ☐ yes ☐ no		What are their names and ages?		
Have you ever received chiropractic care before? ☐ yes ☐ no If Yes, approximate date of your last visit:			Spinal x-rays taken in the last 12 months? ☐ yes ☐ no Body Part(s): ___________________________	
How did you find out about our office? Whom may we thank for referring you into our office?				

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which can damage your health expression. With this case history, our goal is to uncover the layers of injury or damage (especially to your spine and nervous system) that result in lowered health. Following your consultation, the Doctor may recommend a specific course of examinations in order to determine whether you have spinal nerve stress causing interference with your inborn health potential.

LOSS OF WELLNESS

Since most health problems are present for years (many times undetected) before we are aware of them, please complete the following questions as closely and carefully as possible and so we assess the potential cause of your concerns…

Please check the appropriate answers:

Your birth process…

- Was the delivery: ☐ long &/or difficult (# of Hrs:) ☐ forceps ☐ caesarean ☐ vacuum extraction ☐ breech
- Was your mother given: ☐ drugs ☐ epidural ☐ induced – gel or drip?
- Other complications?: ____

Growth and development…

- Were you taught how to care for your spine: ……….☐ yes ☐ no
- Were you breast fed? ………………………………………☐ yes ☐ no How long? _______
- Did you have (please circle): Childhood falls Accidents Sports injuries Auto Collisions Other: ____________________

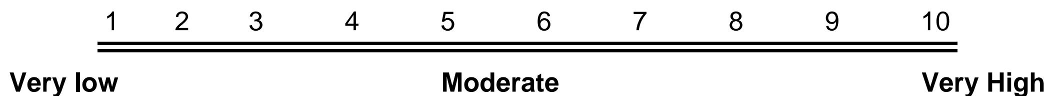
Past Health History

- Have you ever been hospitalized? ☐ yes ☐ no Why?_________________ When______
- Have you ever had surgery? ☐ yes ☐ no Why?_________________ When______
- Have you ever had a broken bone? ☐ yes ☐ no Where?_______________ When______

Current Health Habits…

- Do you smoke? ……………………………………………… ☐ yes ☐ no ______ packs/week
- Do you drink any alcohol?………………………………… ☐ yes ☐ no ______ beverages/week
- Do you go to the dentist for regular check-ups (min.1/yr)..☐ yes ☐ no
- Do you exercise regularly? ………………………………… ☐ yes ☐ no

- Do you belong to a gym or sports club? …………………. □ yes □ no
- Sleeping posture: side □ stomach □ back □ restless # of pillows____
- How long do you sleep per night? Total ______ hrs.
- Rate your stress level on an average day (Select number):



Very low **Moderate** **Very High**

FAMILY HEALTH HISTORY

- What significant health concerns have your family members experienced?
  Parents / Siblings: ____

  Spouse/ Partner: ____

"The spine is the most overlooked and neglected part of a child's health."

- Have your children ever had a chiropractic check-up? □ yes □ no
  If yes, Where_________________ When _________________________

- Do your children suffer from any of the following… (please tick)
  Earaches Tonsillitis Headaches Allergies Frequent colds (3 or more/year)
  Asthma Bronchitis Bed wetting Growing Pains
  Other problems: ____

SYMPTOMS OF ILL HEALTH (Present State of Ill health)

Years of uncorrected injury or damage show up as acute or chronic symptoms or health problems.

Main Purpose for this appointment: ____

When did this condition begin? ____

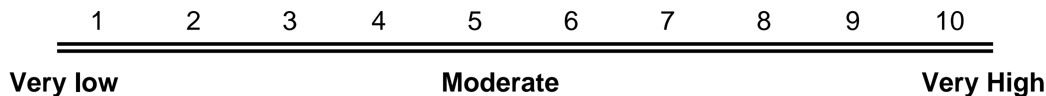
Have you tried anything else to get rid of the problem? ____________________________________

Are you taking any medications? yes no Which one(s):______________________________
____

At its worst, this problem interferes with: your ability to work hobbies/sports family/social time
Other: ____
____
____

If this problem is not corrected, do you think it will get worse in the next 5-10 years? yes no

On a scale of 1 to 10 (10 being the highest), what is your commitment to getting this problem corrected and improving your health. (Select number):



Very low **Moderate** **Very High**

Damage to the spine and nervous system can affect vital functions of the body which will present as warning signals. Please check body warning signals that are or have caused you problems in the last 12-18 months…

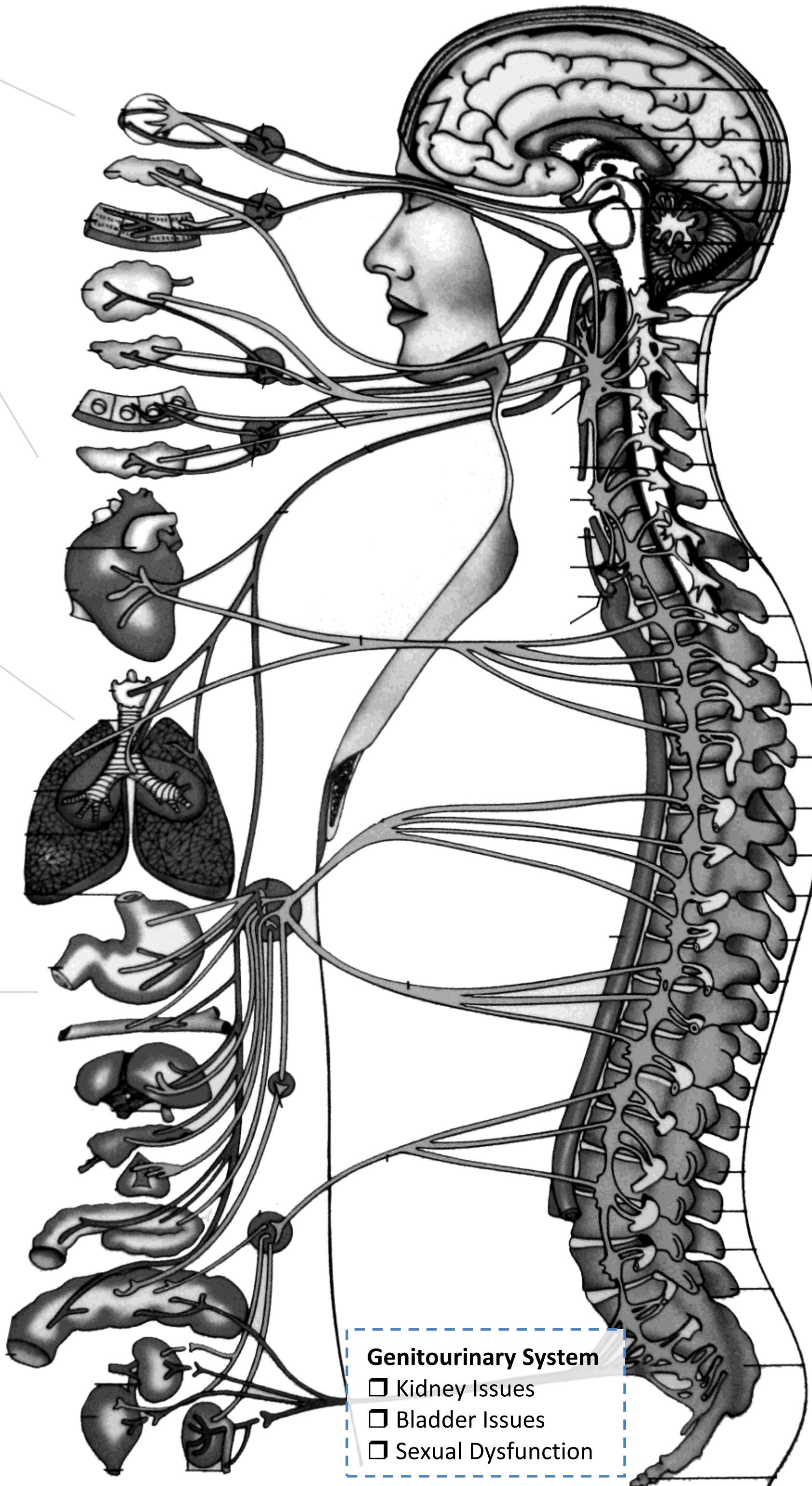
- ❒ Blurred/Failing Vision
- ❒ Deafness / Ear Ringing
- ❒ Earaches
- ❒ Sore Throat/Tonsillitis
- ❒ Thyroid Problems
- ❒ Sinus Problems

Cardiovascular System
- ❒ Chest Pain
- ❒ Shortness of Breath
- ❒ High Blood Pressure
- ❒ High Cholesterol
- ❒ Swelling of Legs
- ❒ Stroke (TIA)
- ❒ Heart Disease
- ❒ Fainting

Respiratory System
- ❒ Frequent Bronchitis
- ❒ Pneumonia
- ❒ Chronic Cough
- ❒ Difficulty Breathing
- ❒ Asthma

Digestive System
- ❒ Heartburn / Indigestion
- ❒ Stomach Cramps
- ❒ Constipation/Diarrhea
- ❒ Food Allergy
- ❒ Irritable Bowels
- ❒ Crohn's Disease
- ❒ Ulcerative Colitis
- ❒ Belching/Gas
- ❒ Nausea or Vomiting
- ❒ Liver Trouble
- ❒ Gall Bladder Trouble
- ❒ Colon Trouble
- ❒ Bloody / Black Stool

Musculoskeletal System
- ❒ Painful Joints
- ❒ Painful Muscles
- ❒ Tendinitis
- ❒ Bursitis
- ❒ Arthritis



Genitourinary System
- ❒ Kidney Issues
- ❒ Bladder Issues
- ❒ Sexual Dysfunction

- ❒ Neck Pain
- ❒ Neck Stiffness
- ❒ Headaches
- ❒ Migraines
- ❒ Arm Pain (L/R/Both)
- ❒ Arm Numbness (L/R/B)
- ❒ Arm Tingling (L/R/B)
- ❒ Hand Pain (L/R/B)
- ❒ Hand Numbness (L/R/B)
- ❒ Hand Tingling (L/R/B)
- ❒ Dizziness
- ❒ Arthritis
- ❒ Poor Posture
- ❒ Allergies
- ❒ Scoliosis

- ❒ Pain Between Shoulders
- ❒ Tension Across Shoulders
- ❒ Mid-Back Stiffness
- ❒ Mid-Back Pain

- ❒ Skin Problems
- ❒ Learning Disability
- ❒ Irritable/Nervous/Tension
- ❒ Depression/Emotional
- ❒ Tired/Fatigued
- ❒ Loss of sleep
- ❒ Anemia
- ❒ Tremors
- ❒ Low Back Pain
- ❒ Hip Pain
- ❒ Sciatica
- ❒ Leg Pain (L/R/Both)
- ❒ Leg Numbness (L/R/B)
- ❒ Leg Tingling (L/R/B)

Females Only
- ❒ Painful Menstruation
- ❒ Cramps or Backaches
- ❒ Menopause
- ❒ Excessive/Irregular Flow
- ❒ Abnormal Discharge
- ❒ Miscarriages # ________

Pregnant? ❒ Yes ❒ No

Due Date: ______________

Date of last menstrual period: ________________

By signing here, I verify that the information provided on this form is true and accurate regarding my health history.

Signature: ____ Date: ________________

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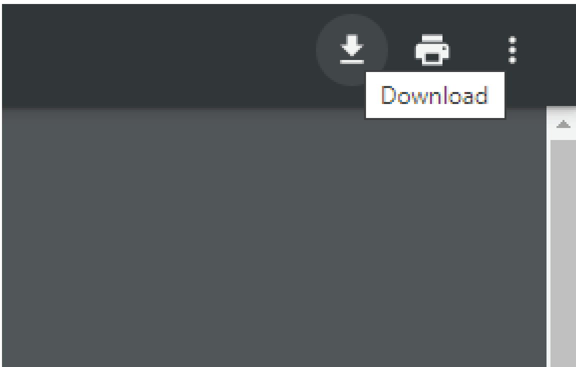
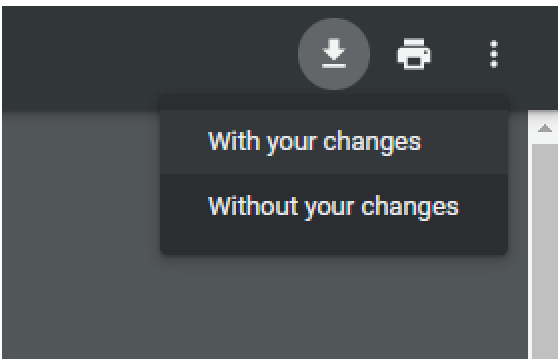
INSTRUCTIONS TO SUBMIT PAPERWORK:

Step 1: Fill in your information in all required fields.

Step 2: When completed, click on 'Download' in the top right-hand corner.



Step 3: Choose the option for "With your changes". Save the file with your first and last name in the file name.



Step 4: Attach the document in an email to **info@snelgrovechiropractic.com**