SNELGROVE CHIROPRACTIC
Family Wellness Centre

CONFIDENTIAL ADULT PATIENT HEALTH RECORD

DATE:

Name:			Email Address:	
Address:			City:	Postal Code:
			Home Phone: ( )	Work/Cell Phone: ( )
Age:	Sex: □ M □ F	Date of Birth: (mm/dd/yyyy)	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?				

WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you into this office and offer you the opportunity of improved health potential and wellness services in the future. Each day we experience physical, chemical, and emotional stress that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious.

THE BEGINNING YEARS (to age 17)

Research is showing that most of the health challenges that occur later in life have their origins during childhood and adolescent years, some starting at birth. Please answer the following questions to the best of your ability.

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 (circle number):

1 2 3 4 5 6 7 8 9 10

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

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have:

Children: _____

Spouse:_____

Mother/Father:_____

Brother(s)/Sister(s):_____

Others: _____

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. (circle a number):

1 2 3 4 5 6 7 8 9 10

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…

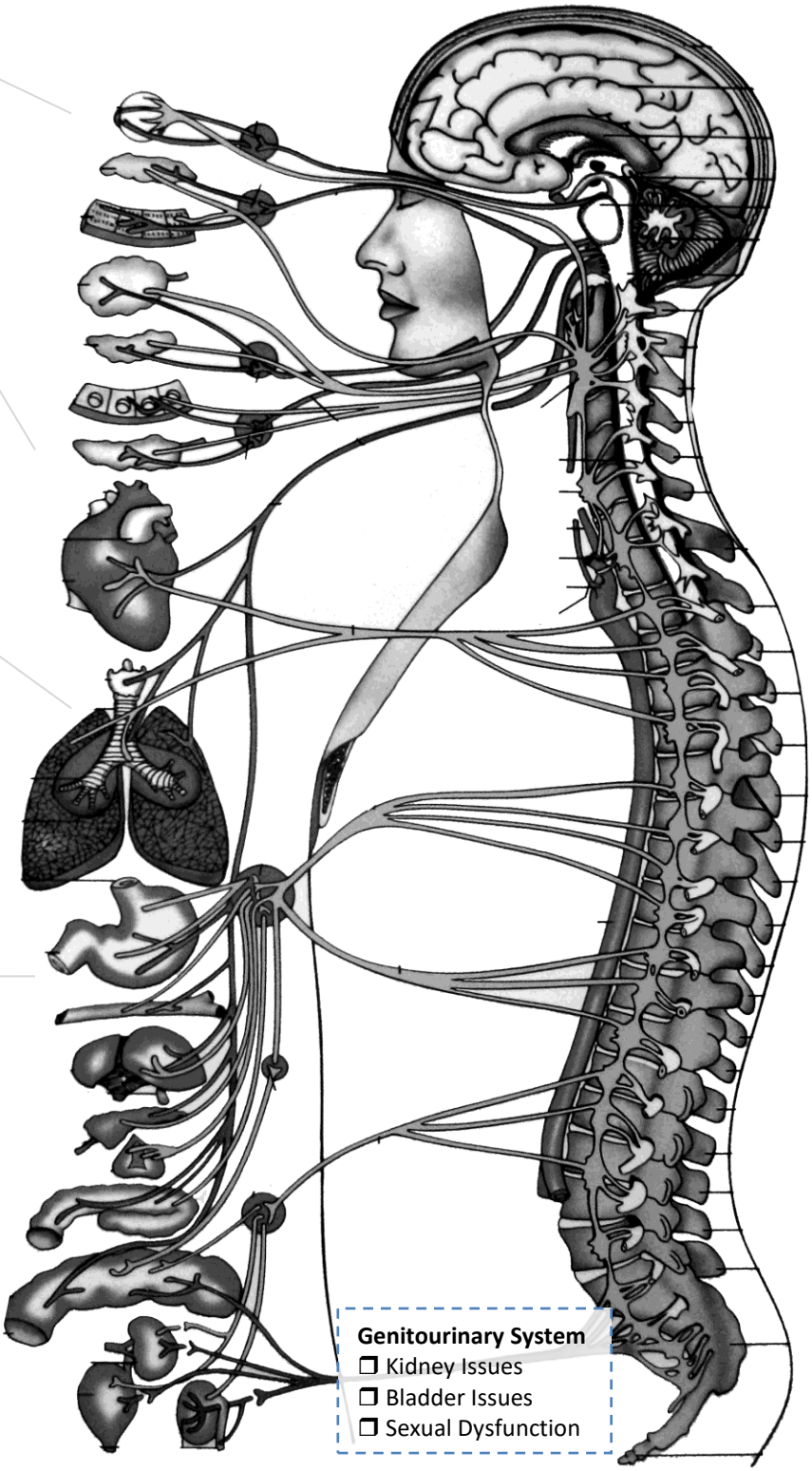
❒ Blurred/Failing Vision
❒ Deafness / Ear Ringing
❒ Earaches
❒ Sore Throat/Tonsillitis
❒ Thyroid Problems
❒ Sinus Problems

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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