CENTRAL HEALTH CHIROPRACTIC

PERSONAL HISTORY

Name_____ **Address**_____

City _____**Province** _____ **Postal Code** _____ **Telephone (H)**_____

(C) _____**(W)** _____**(Email)** _____

Birthdate DD / MM / YYYY **Age** _____**Sex M F Status M S W Children: Boys:**_____**Girls** _____

Occupation _____**Employer** _____

Family Medical Doctor _____ **Location**_____ **Phone**_____

How Did You Hear About Our Office: Sign Phonebook Walk-In Referral:_____

PLEASE CHECK ALL ANSWERS AND FILL IN THE BLANKS WHERE APPROPRIATE. DESCRIBE YOUR PRESENT COMPLAINT. This information is necessary to assist your health care provider understand your health condition.

Present Complaint:_____

Have you been previously treated for this? _____

When did this condition begin?_____

What do you believed caused this condition?_____

Have you lost any time from work?_____

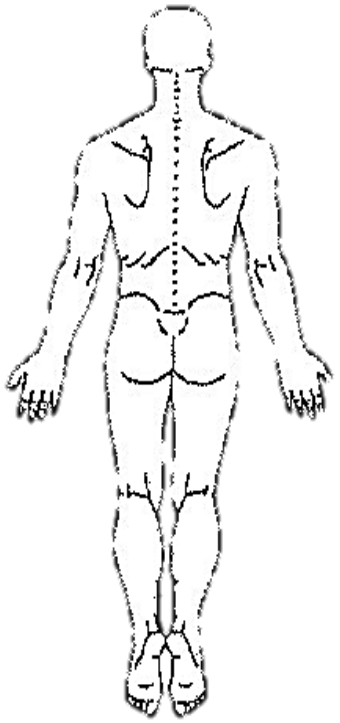
Is this a WCB claim?_____

Is this a result of a Motor Vehicle Accident?_____

What Medications, prescribed or otherwise, are you currently taking?_____

_____

PLEASE OUTLINE THE AREAS OF YOUR DISCOMFORT



PAST HEALTH HISTORY

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU NOW OR IN THE PAST:

MAJOR SURGERIES:

- ☐ **Appendix**
- ☐ **Hernia**
- ☐ **Back**
- ☐ **Shoulder/Elbow/Wrist/Hand**
- ☐ **Others (List):**
- ☐ **Tonsils**
- ☐ **Heart/Blood Vessels**
- ☐ **Neck**
- ☐ **Hip/Knee/Ankle/Foot**

Please list any major accidents or falls:_____

Previous Chiropractic Care (Name and Date of Last Visit):_____

_____

Have you been treated for **any** health conditions in the past year?_____

DO NOT WRITE BELOW – DOCTOR ONLY

DIAGNOSIS:_____

TREATMENT ALERT:_____

PAST HEALTH HISTORY (cont.)

GENERAL

- ☐ Headache
- ☐ Numbness/Pain in arms or legs
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Whiplash
- ☐ Fainting
- ☐ Earache
- ☐ Sore Throat
- ☐ Nose Bleeds
- ☐ Sinus Problems
- ☐ Asthma
- ☐ Enlarged glands
- ☐ Weight Loss
- ☐ Hypoglycemia
- ☐ Diabetes
- ☐ Depression
- ☐ Confusion
- ☐ Vision Problems
- ☐ Hearing Problems

ORGANS

- ☐ Frequent Urination
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Bladder Problems
- ☐ Kidney Stones
- ☐ Bed Wetting
- ☐ Prostate Problems
- ☐ Sexual Problems
- ☐ Anemia
- ☐ Thyroid Problems
- ☐ Excessive Appetite
- ☐ Gas/Bloating
- ☐ Nausea/Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colitis
- ☐ Irritable bowel
- ☐ Black or Bloody Stool
- ☐ Liver Problems
- ☐ Gall Bladder Problems

SKIN

- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin Eruptions
- ☐ Varicose Veins

MUSCLE/JOINTS

- ☐ Low Back Problems
- ☐ Neck Problems
- ☐ Problems b/w shoulder blades
- ☐ Spinal Curvature
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Sore Muscles
- ☐ Difficulty Walking
- ☐ Broken Bones
- ☐ Jaw Pain
- ☐ Swelling in Extremities
- ☐ Limb Pain

RESPIRATION/HEART

- ☐ Lung Problems
- ☐ Chronic Cough
- ☐ Coughing up Blood
- ☐ Frequent Cold/Flu
- ☐ Shortness of Breath
- ☐ Breathing Difficulties
- ☐ Heart Problems
- ☐ Blood Disorders

FEMALES ONLY

- ☐ Painful Periods
- ☐ Irregular Cycle
- ☐ Cramps/Backache
- ☐ Vaginal Discharge
- ☐ Vaginal Infection
- ☐ Breast Pain/Lumps
- ☐ Menopausal Symptoms
- ☐ Miscarriage
- ☐ Are You Pregnant?_____
- ☐ When was your last period?_____

Check Any of the Following Diseases You Have Had:

- ☐ Alcoholism
- ☐ Tuberculosis
- ☐ Allergies
- ☐ High Blood Pressure
- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ Epilepsy
- ☐ HIV/AIDS
- ☐ Stroke
- ☐ Diabetes
- ☐ Lupus
- ☐ Cancer
- ☐ Polio
- ☐ Arthritis
- ☐ Meningitis

Check Any Diseases That Have Occurred In Family Members:

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Cancer
- ☐ Arthritis
- ☐ Diabetes
- ☐ Bowel Disease
- ☐ Stroke

Please Assess Your Habits:

	None	Light	Moderate	Heavy
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tea	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Junk Food	☐	☐	☐	☐
Water	☐	☐	☐	☐
Stress	☐	☐	☐	☐