



# CENTRAL HEALTH CHIROPRACTIC



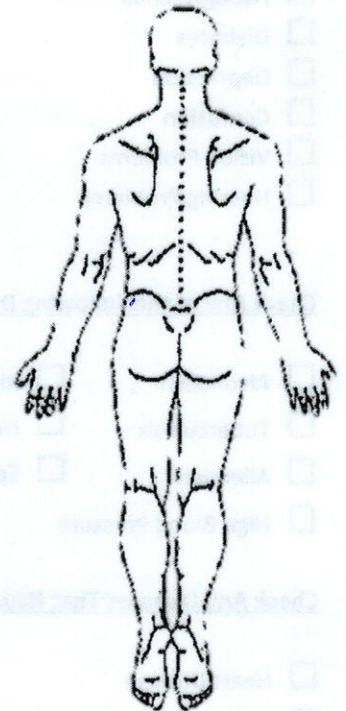
## PERSONAL HISTORY

Name \_\_\_\_\_ Address \_\_\_\_\_  
 City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Telephone (H) \_\_\_\_\_  
 (C) \_\_\_\_\_ (W) \_\_\_\_\_ (Email) \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex M F Status M S W Children: Boys: \_\_\_\_\_ Girls \_\_\_\_\_  
 Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
 Family Medical Doctor \_\_\_\_\_ Location \_\_\_\_\_ Phone \_\_\_\_\_  
 Emergency Contact- Name \_\_\_\_\_ Phone Number \_\_\_\_\_ Alberta Health Care# \_\_\_\_\_  
 How Did You Hear About Our Office: Sign Internet Walk-In Echo 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.

## PLEASE OUTLINE THE AREAS OF YOUR DISCOMFORT

Present Complaint: \_\_\_\_\_  
 Have you been previously treated for this? \_\_\_\_\_  
 When did this condition begin? \_\_\_\_\_  
 What do you believe 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? \_\_\_\_\_



## PAST HEALTH HISTORY

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

### MAJOR SURGERIES:

- |   |  |
|---|--|
| <input type="checkbox"/> Appendix                   | <input type="checkbox"/> Tonsils             |
| <input type="checkbox"/> Hernia                     | <input type="checkbox"/> Heart/Blood Vessels |
| <input type="checkbox"/> Back                       | <input type="checkbox"/> Neck                |
| <input type="checkbox"/> Shoulder/Elbow/Wrist/H and | <input type="checkbox"/> Hip/Knee/Ankle/Foot |
| <input type="checkbox"/> Others (List): _____       |  |

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:**

- |  |  |                                   |                                     |
|--|--|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Cancer     |
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Stroke   | <input type="checkbox"/> Polio      |
| <input type="checkbox"/> Allergies           | <input type="checkbox"/> Epilepsy        | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis  |
| <input type="checkbox"/> High Blood Pressure |  | <input type="checkbox"/> Lupus    | <input type="checkbox"/> Meningitis |

**Check Any Diseases That Have Occurred In Family Members:**

- |  |  |
|--|--|
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Diabetes      |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bowel Disease |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Arthritis           |  |

**Please Assess Your Habits:**

	None	Light	Moderate	Heavy
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"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Junk Food	<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"/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I give consent to Central Health Chiropractic & Wellness to send me appointment reminders via:

- Text
- Email