Active Chiropractic

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Confidential Patient History

Personal Information

Name: _____ Name of Preference: _____

Sex: M / F Marital Status: S C.L. M D W Date of Birth: ___ /___ /____(Day/Month/Year) Age: _____

Address: _____City/Town: _____Postal Code: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Email address: (for clinic use only) _____

Occupation: _____ Name of Business:_____

Spouse's name: _____ Children: _____

Alberta Health Care #: __/__/__/__/__ - __/__/__/__ **Emergency Contact:** _____**Ph.#** _____

How did your hear about our office? _____

Health Status

What is your reason for visiting our office?

_____

_____

Is your present condition the result of?

Î Auto Accident Î Work Injury Î Personal Injury Î Other

When did this problem begin?

_____

What activities aggravate this condition?

_____

What relieves it?

_____

Is this condition interfering with Î Work Î Sleep Î Daily Routine Î Other

Please explain: _____

_____

Have you had a similar problem in the past? Please list dates.

_____

Have you seen a chiropractor previously? Please give name and date of last visit.

_____

Results: Excellent:_____ Good:_____ Fair:_____ Poor:_____

Have you received any other treatment for this condition? Please list type and date of treatment._____

_____

Medical Doctor's Name: _____ Date of Last Physical: _____

Please list all past and present medical conditions and medications you are currently taking.

_____

_____

_____

Do you wear Î Arch supports Î Heel lifts Î Custom Orthotics

How long has it been since you really felt good? Î I feel great ... I want to optimize my health!
Î Days Î Weeks Î Months Î At least a year Î Years!

Please circle:

Rate your diet:	Poor	Fair	Medium	Good	Excellent
Rate your sleep habits:	Poor	Fair	Medium	Good	Excellent
Rate your exercise:	Poor	Fair	Medium	Good	Excellent

What are your expectations regarding our office and your experience here?

_____

Using the line scale provided below, rate the level of pain you are experiencing.

0 ....1 ....2 ....3 ....4 ....5 ....6 ....7 ....8 ....9 10

No pain Severe pain

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

To complete the picture, please draw in your face.

Numbness _____
_____

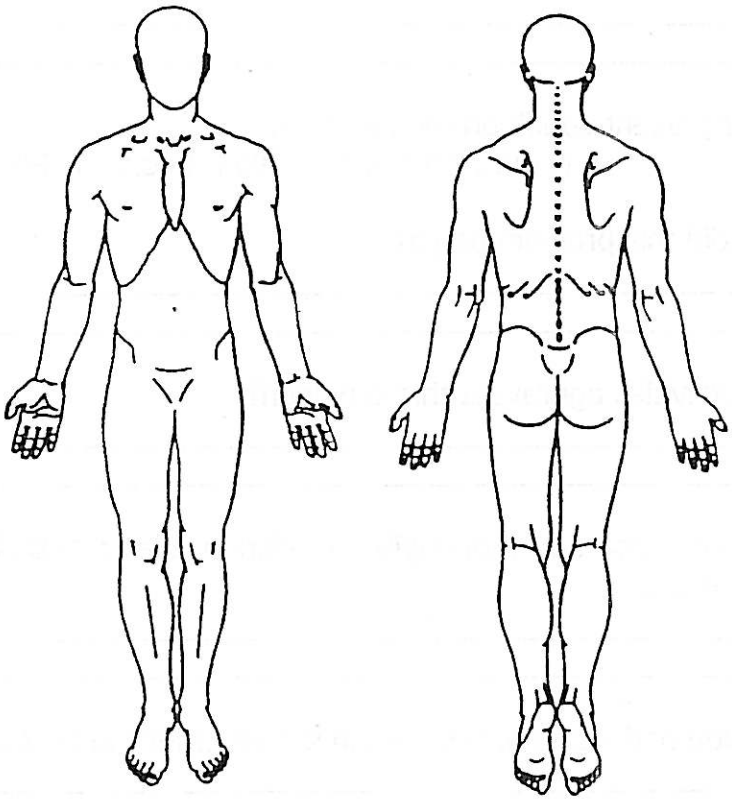
Pins & Needles .....
.....

Burning XXXXX
XXXXX

Dull & Aching ++++++
++++++

Stabbing //////////
//////////

Stiff & Tight 2222222
2222222



Name: _____ **Date:** _____

Symptoms & Health History

Please circle any conditions or symptoms presently causing you problems.

Please check (√) those conditions or symptoms which have been a problem to you in the past.

GENERAL SYMPTOMS
Loss of consciousness
Blackouts
Headache
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions
Loss of sleep
Numbness, pain or tingling
Nervousness
Loss of weight

MUSCLE & JOINTS
Stiff neck
Backache
Swollen joints
Painful tail bone
Foot trouble
Shoulder trouble
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Arthritis
Weakness or loss of strength

E.E.N.T
Blurred vision
Failing vision
Crossed eyes
Double vision
Eye pain
Deafness
Earache
Ringing, buzzing, noise in ears
Asthma
Frequent colds
Sinus infection
Enlarged glands
Enlarged thyroid
Slurred or other speech problems
Difficulty swallowing

RESPIRATORY
Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficulty breathing

CARDIOVASCULAR
Bleeding disorder
High blood pressure
Low blood pressure
Pain over heart
Stroke
Hardening of arteries
Varicose veins
Swelling of ankles
Poor circulation
Heart or blood disease
Angina

GENITOURINARY
Trouble urinating
Blood in urine
Kidney infection
Bed wetting
Prostate trouble

G.U. FOR WOMEN
Painful menstruation
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Vaginal discharge
Swollen breasts
Lumps in breasts

Have you ever been on birth control pills? Yes! No!

Are you currently taking birth control pills? Yes! No!

children _____
Pregnant? _____
Due Date? _____
Menopausal? _____

SKIN
Rashes, itching
Bruise easily
Dryness
Boils
Hives (allergy)

GASTROINTESTINAL
Poor appetite
Indigestion
Excessive hunger
Belching or gas
Nausea
Vomiting (blood?)
Pain over stomach
Constipation
Diarrhea
Hemorrhoids
Jaundice
Gall bladder trouble
Intestinal worms
Ulcer
Diabetes
Irritable Bowel Syndrome
Ulcerative Colitis
Crohn's

Have you ever had any fractures? Yes! No!

Have you ever been in a car accident? Yes! No!

Have you ever been hospitalized? Yes! No!

Have you ever had surgery? Yes! No!

Have you ever smoked? Yes! No!

Are you currently a smoker? Yes! No!

List your medications:
_____