NEW PATIENT HEALTH HISTORY FORM

Patient Data

Name:_____ **M / F** Address: _____
City:_____ Province: _____ Postal Code:_____
Phone: H:_____ W:_____ Ext: _____ C: _____
Birth Date:_____ Age: _____ Spouse:_____
Kids? **Y** **N** Names and Ages:_____
Your Occupation:_____ Family Physician:_____
Previous Chiropractor:_____ Reason for discontinuing?_____
Whom shall we thank for referring you to our office?_____
Do you have health insurance?_____ Name of company:_____ Plan number:_____
* Your Best Email Address:_____

Your email address will NOT be shared with anyone and will be used to email you your financial statements and for occasional office announcements. We are moving towards an entirely paperless office, so please help us by providing your email address. Thank you!

Current Health Profile

Your Main Complaint:_____
Secondary Complaints:_____
How long have you suffered with this problem?_____
What makes this problem worse?_____ Better? _____
What is the pattern of this problem (circle)? *constant* *occasional* *comes and goes* *worsening*
How did it start?_____
Do you experience pain at night? **Y** **N** Night sweats? **Y** **N** Unexplained weight loss? **Y** **N**
If you are experiencing pain, is it (circle): *dull* *sharp* *pins/needles* *burning* *tight* *throbbing*
What does it interfere with (circle): *work* *sleep* *walking/standing* *sitting* *hobbies/leisure* *family*
Names of other doctors seen for this problem: _____
Please circle the intensity of your problem:
(no pain/feeling great) **1 ------ 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10** (worst pain imaginable)

Health History

Do you smoke? **Y** **N** How many Years?_____ # Packs/day?_____
Are you on any type of medication? **Y** **N** Please list: _____
_____

Do you take any supplements? **Y** **N** Please list:_____
Any surgeries? _____

My past health history has been (circle): *poor* *ok* *good* *very good* *excellent*
I suffer from (circle): *high cholesterol* *diabetes* *cancer* *osteoporosis* *arthritis* *high blood pressure*
Other: _____

Have you been involved in an auto accident? **Y** **N** Date of accident: _____

Please think of past traumas in your life (minor car accidents, falls, traumatic birth, sports injury, falls as a child, etc**).** *It is important that you complete this as best as you can. List your top 3:*

1. _____
2. _____
3. _____

Please check all that apply:

- ❑ Low Back Pain
- ❑ Pain Between Shoulders
- ❑ Neck Pain
- ❑ Headaches / Migraines
- ❑ Tired / Fatigued
- ❑ Tight Muscles
- ❑ Fibromyalgia
- ❑ Tension across shoulders
- ❑ Stress
- ❑ Forgetfulness
- ❑ Miscarriage(s)
- ❑ Liver/gall bladder problems
- ❑ High blood pressure
- ❑ Numbing-Tingling in Hands/Feet
- ❑ Numbing-Tingling in Arms/Legs
- ❑ Dizziness
- ❑ Ringing in Ears
- ❑ Nervousness
- ❑ Attention Deficit Disorder
- ❑ Frequent colds
- ❑ Difficulty Sleeping
- ❑ Thyroid problems
- ❑ depression
- ❑ Allergies / Sinus Problems
- ❑ Diarrhea / Constipation
- ❑ Asthma/allergies
- ❑ Menstrual Cramps
- ❑ Weight Trouble
- ❑ Foot /Ankle Pain
- ❑ Mood swings
- ❑ Upset stomach
- ❑ Sexual dysfunction
- ❑ Ankle swelling
- ❑ Bladder trouble
- ❑ Heartburn
- ❑ Chest pain
- ❑ Walking problems
- ❑ Confusion
- ❑ Balance problem

I participate in/do (circle): *prolonged computer work* *sports* *prolonged postures* *sleep face down*

What can't you do right now that is preventing you from fully enjoying your life?_____

_____

What are your long-term health goals?_____

_____

Please rate your level of commitment to resolving your problem(s)(10 being the highest): ___

Lifestyle

Habit		None	Light	Moderate	Heavy
Alcohol	***please check appropriate box***				
Tobacco					
Exercise					
Sleep					
Appetite					
Soft Drinks					
Water					
Salty Foods					
Sugary Foods					
Artificial Sweeteners					
Coffee					

For Women Only

Are you pregnant? **Y** **N** Date of your last menstrual period:_____
Are you using any means of contraception? **Y** **N**
Do you experience severe cramping with your menstrual period? **Y** **N**
Do you suffer from PMS? **Y** **N**

Additional Information

Is there any other pertinent information you would like us to know? **Y** **N**

_____

I give my consent to have the doctor(s) perform an exam and take any x-rays that are deemed appropriate to better understand my problem and monitor my progress.

Print Name:_____
Signature: _____ Date: _____
(Signature of parent/guardian required if patient under age 18)