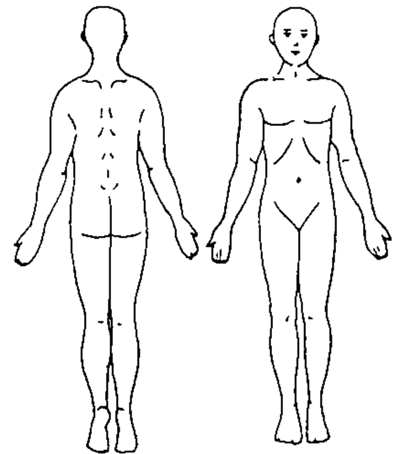
Southern Chiropractic - Health History

Date:	Alberta Health Care Number:		
Patient's Last Name:	First Name:		Home Phone:
Mailing Address:	City/Town:	Postal Code:	Email (optional):
Date of Birth: Gender:	Occupation:		Business Phone:
Employer:	Business Address:		
Marital Status: Name of Spouse:	Occupation:	Emergency Name & Contact Number:	
Ages of Children:	Who is Legally responsible for this account?		
Who referred you to our office?			

Have you had previous Chiropractic care? ☐ Yes ☐ No
Name of Chiropractor: ____________ Date of Last Visit: ________________________
City/Town: _______________________________ X-rays taken? ☐ Yes ☐ No
Why did you seek care?

Major Complaint:

Please outline on the diagram the area of your discomfort



Is this a work related injury? ☐ Yes ☐ No
Where is your major complaint? ______________________________
Date of onset: (D) __________ /(M) __________ /(Y)__________
Onset was: ☐ Sudden ☐ Gradual ☐ Associated with an Event
Has the problem been: ☐ Constant ☐ Intermittent ☐ Occasional
Indicate the **present intensity** of the pain by circling the appropriate number:
(Mild) 1 2 3 4 5 6 7 8 9 10 (Very Intense)
What does the pain feel like?
☐ Dull ☐ Aching ☐ Burning ☐ Throbbing ☐ Sharp
Does it move anywhere? ____
What activities aggravate your condition? ______________________
What makes it better? ____
Does this limit your daily activities? ☐ Yes ☐ No
If so, which activities are affected? __________________________________
Have you had this or a similar condition in the past? ☐ Yes ☐ No
If so, when? ____
Any related family history?____
Any other complaints? ____

Health History:

Have you been in an auto accident? ☐ Yes ☐ No Date(s): ____________________
Describe: ____
Have you had any other physical injuries? ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years
☐ Childhood Please Describe: ____

During your day, do you engage in prolonged: ☐ Sitting ☐ Standing ☐ Driving ☐ Computer
What position do you sleep in? ☐ On Back ☐ On Side ☐ On Stomach ☐ Combination

Are you currently taking of the following: ☐ Aspirin/Tylenol ☐ Birth control pills ☐ Pain killers ☐ Vitamins ☐ Muscle relaxants ☐ Anti-inflammatories Others: ___________________

Do you smoke? ☐ Yes ☐ No If so, How many per day? _____ For how long? _______________
Please list any surgical operations and the years they were performed: ___________________________
____
Name of family Doctor: ____

Have you ever had?

☐ Diabetes ☐ Cancer ☐ Heart Disease ☐ Asthma
☐ Epilepsy ☐ Arthritis ☐ Stroke ☐ Seizure

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, please answer these questions carefully as these problems can affect your overall diagnosis and treatment and influence the possibility of being accepted for chiropractic care.

Check any of the following you HAVE or HAVE HAD in the past 6 months.

Musculo-Skeletal: ☐ Headaches ☐ Low back pain ☐ Pain between Shoulders ☐ Neck Pain ☐ Arm Pain ☐ Difficulty Chewing/Clicking Jaw

Nervous System: ☐ Numbness ☐ Paralysis ☐ Depression ☐ Fainting ☐ Convulsions ☐ Cold/Tingling Extremities

General: ☐ Ear aches ☐ Allergies ☐ Loss of sleep

Gastro-Intestinal: ☐ Poor/Excessive Appetite ☐ Excessive Thirst ☐ Frequent Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Hemorrhoids ☐ Liver Trouble ☐ Gall Bladder Problems ☐ Gas/Bloating after meals ☐ Abdominal Cramps ☐ Colitis ☐ Black/Bloody Stool ☐ Heartburn

Genito-Urinary: ☐ Bladder Trouble ☐ Painful/Excessive Urination ☐ Discoloured Urine

Cardiovascular: ☐ Chest Pain ☐ Short of Breath ☐ Blood Pressure Problems ☐ Irregular Heartbeat ☐ Heart Problems ☐ Lung Problems/Congestion ☐ Varicose Veins ☐ Ankle Swelling

Female Only: ☐ Menstrual Irregularity ☐ Menstrual Cramping
When was your last period? ____________________
Are you pregnant? ☐ Yes ☐ No ☐ Maybe