A Total Approach to Health and Wellness

HEALTH HISTORY

(Please answer all questions, even if they seem unrelated to your case.)

Name: ______________________________ AHC# __________________________ Date: _________________

Ph: (H) ☐ ______________________ (W) ☐ ________________________(C) ☐ __________________________
(Check your preferred phone number above.)

Address: ____ Postal Code: _____________

E-Mail Address: ____ Birthdate: _________________
(dd/mm/yyyy)

Age: _____ Wt: _____ Ht: _____ Children: ___ Birthplace: _______________

Sex: ☐ Male ☐ Female Title: □Mr □Mrs □Miss □Ms Marital Status: __________________

Occupation: _________________________________Employer: ______________________________________

Healthcare insurance? (Manulife, Blue Cross, etc.) ____

Emergency Contact: _____________________________________ Ph: _________________________

How did you find out about us?

☐ Healthcare Provider
☐ Special Event
☐ Can Pages
☐ Radio
☐ Lawyer
☐ Here Before
☐ Yellow Pages
☐ Other_______________
☐ Employer
☐ Website
☐ Family/Friends
☐ Clinic Materials
☐ Special Offer
☐ Signage

Who referred you? ____

Present Complaint: ____
When did this condition begin?____
What caused this condition? ____
Have you ever had this condition before? ____
Are your symptoms getting □ better □ worse □ staying the same □ constant □ comes and goes
On a scale of 0-10 how severe is your pain? (0=no pain, 10=excruciating)______________________
What makes it better?____
What makes it worse?____
Is this work related? □ Or a motor vehicle accident? □ Date of injury/accident? _________________________
Are you here for treatment due to: □ Surgery? □ Fracture? Date of occurrence?_________________________
Do you have pain or difficulties with your: □ hip □ leg □ feet?

Please complete the following chart:

Prescription Medication (Include Birth control)	**Over the Counter Medication** (e.g. Tylenol, Advil, etc.)	**Vitamins & Supplements**

When was your last treatment?
Chiropractic: ____________ Physiotherapy: ____________ Massage:____________ Acupuncture:____________

Have you been treated for any health condition in the last year? ☐Yes ☐ No If yes, list any upcoming/recent tests or surgeries.____

Have you had x-rays or tests for this condition? □ If so, When?_____________ Results?_________________
When was the last time you really felt well? ____

(PLEASE COMPLETE THE INFORMATION ON THE OTHER SIDE)

How important is your health to you on a scale of 1 – 10, 10 being most important? ______________________

Provide dates of ALL surgeries, fractures and major illnesses:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

List ALL motor vehicle accident dates and other major accidents or falls: (please describe)

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Please √ and list any of the following devices that you currently wear or are implanted:

☐ prosthetic devices __________________________ ☐ hearing aids ☐ orthotics

☐ implants(pins/wires/artificial joint) ________________ ☐ pacemaker ☐ heal lifts/inserts

Check √ any conditions which are **presently** causing you a problem.
Please underline conditions which **were** a problem in the past.

GENERAL

☐ headache
☐ migraines
☐ dizziness
☐ ringing in ears
☐ fainting
☐ earache
☐ sore throat
☐ nose bleeds
☐ sinus problems
☐ asthma
☐ enlarged glands
☐ unexplained weight loss
☐ hypoglycemia
☐ nervousness/anxiety
☐ depression/confusion
☐ vision problems
☐ dental problems
☐ hearing problems
☐ fever
☐ night sweats
☐ osteoporosis
☐ hyper/hypoglycemia

ORGANS

☐ frequent urination
☐ painful urination
☐ blood in urine
☐ bladder problems
☐ kidney stones
☐ bed wetting
☐ prostate problems
☐ sexual dysfunction
☐ anemia
☐ eating disorders
☐ thyroid problems
☐ excessive appetite
☐ gas / bloating
☐ nausea /vomiting
☐ constipation /diarrhea
☐ colitis/Chrons/IBS
☐ black / bloody stool
☐ hemorrhoids
☐ liver problems
☐ gall bladder
☐ rheumatic fever

SKIN

☐ eczema
☐ skin eruptions
☐ varicose veins
☐ rashes
☐ loss of sensation/pins and needles
☐ varicose veins
☐ sensitivity to tape/lotions
☐ contagious conditions

☐ **MUSCLE & JOINT**

☐ neck problems
☐ whiplash
☐ upper back problems
☐ low back problems
☐ tailbone pain
☐ spinal curvature
☐ pelvic numbness and/or pins & needles
☐ limb problems
☐ walking problems
☐ arthritis
☐ rheumatoid arthritis
☐ sore joints
☐ sore muscles
☐ jaw problems

RESPIRATIORY & HEART

☐ lung problems
☐ chronic cough
☐ spitting up blood
☐ frequent colds/flu
☐ difficult breathing
☐ heart problems
☐ swollen ankles
☐ high/low blood pressure

FEMALES ONLY

☐ painful periods/PMS
☐ irregular cycle
☐ cramps, backache
☐ vaginal discharge/infection
☐ lumps/pain in breast
☐ menopausal symptoms
☐ previous miscarriage
☐ unable to get pregnant
☐ hot flashes
☐ recent abortion/delivery
☐ Are you pregnant?
☐ Yes ☐ No ☐ Not Sure

When was your last period?
____

Check any of the following diseases you have (or have had):

☐ alcoholism ☐ HIV ☐ hepatitis ☐ epilepsy ☐ stroke ☐ arthritis ☐ heart disease ☐ heart attack

☐ sexually transmitted diseases ☐ diabetes ☐ cancer ☐ nervous system disorder (eg. MS, CP, Parkinson's) ☐ allergies

☐ other ________

Has anyone in your family had any of the following diseases?

☐ heart disease who _____________ ☐ high blood pressure who _______________ ☐ cancer who ___________ ☐ stroke who ___________ ☐ arthritis who ________ ☐ diabetes who__________

Do you experience any of the following symptoms:

☐ depressed mood ☐ overwhelming sadness ☐ high stress levels ☐ heightened anxiety ☐ elevation of mood ☐ unmanaged pain levels ☐ inability to sleep ☐ inability to focus on the task at hand

Do you currently need help managing:

☐ weight loss ☐ diabetes ☐ allergies ☐ a vegetarian diet

Are you presently suffering from the following:

☐ tension headaches ☐ teeth/jaw pain ☐ bleeding of gums during brushing ☐ mouth sensitivity to pressure and/or temperature. When was the last time you had your teeth cleaned________________________.

Please check any of the following that apply to you. Please use the options: none, light, moderate, or heavy to best describe how often you participate or how much you feel it represents you. For example, do you feel you are under a heavy amount of stress? Do you feel you only drink a light amount of coffee/tea a day (one cup)?

LIFESTYLE	None	Light	Moderate	Heavy		None	Light	Moderate	Heavy
Exercise	☐	☐	☐	☐	Tobacco	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Alcohol	☐	☐	☐	☐
Coffee/Tea	☐	☐	☐	☐	Junk Food	☐	☐	☐	☐
Pop	☐	☐	☐	☐	Stress	☐	☐	☐	☐

Symptom Diagram

Using the symbols below, please draw on the diagram below to indicate the symptoms you have been experiencing in the locations you are experiencing them. Please also draw a face on the diagram.

Numbness = OOOOOOOOOO	Sharp/Stabbing = ++++++++++	Shooting = SSSSSSSSSS
Pins and Needles = **********	Ache/dull pain = ^^^^^^^^^^	Tender = PPPPPPPPP

Right Back Front Left

Indicate on the line how bad your pain or discomfort is.

No Pain |--|--| Worst pain

0 5 10 Ever

Discomfort Discomfort