CONFIDENTIAL HEALTH INFORMATION

All information that you provide us is strictly confidential and
will not be transferred without your permission.

Date
_____ `

Name
_____

First name
_____

Address
_____

_____

Date of birth _____

Phone number _____

Email _____

Have you consulted a chiropractor before?
☐ **Yes** ☐ **No**

Gender
☐ **Male** ☐ **female**

Marital Status
☐ **Single** ☐ **Married**
☐ **Divorced** ☐ **Widowed**

Which health insurance do you have?
☐ **Christian Mut.** ☐ **Liberal Mut**
☐ **Social Mut.** ☐ **Other**

Your Occupation
_____

1. **The symptom(s) that have prompted me to seek care today include:** _____

   _____

2. **And are the result of**
   ☐ An accident or injury
   ☐ Work ☐ Car ☐ Other _____

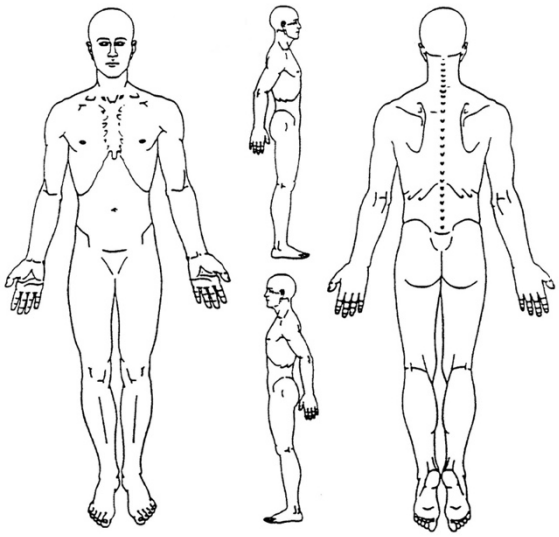
   ☐ A worsening long term problem
   ☐ An interest in: ☐ Wellness ☐ Other _____

3. **Onset** (When did you first notice your current symptoms?) _____

4. **Intensity** (How extreme are your current symptoms?) **0** O-O-O-O-O-O-O-O-O-O-O **10**
   Absent Uncomfortable Agonizing

5. **Duration and timing** (When did it start and how often do you feel it?)
   ☐ Constant ☐ Comes and goes. How often? _____

6. **Location** (Where does it hurt?) Circle the area(s) on the illustration.



7. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel?)

_____

8. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

_____

9. Prior interventions (What have you done to relieve the symptoms?)

☐ Prescription medication	☐ Surgery	☐ Ice
☐ Over-the-counter drugs	☐ Acupuncture	☐ Heat
☐ Homeopathic remedies	☐ Chiropractic	☐ Other: _____
☐ Physical therapy	☐ Massage	

10. Review of Systems

Chiropractic care focusses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have**.

A. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Osteoporosis	☐	☐	Arthritis	☐	☐	Scoliosis	☐	☐	Neck pain	☐	☐	Back problems	☐	☐	Hip disorders
☐	☐	Knee injuries	☐	☐	Foot/ankle pain	☐	☐	Shoulder problems	☐	☐	Elbow /wrist pain	☐	☐	TMJ issues	☐	☐	Poor posture

B. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anxiety	☐	☐	Depression	☐	☐	Headache	☐	☐	Dizziness	☐	☐	Pins and needles	☐	☐	Numbness

C. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	High blood pressure	☐	☐	Low blood pressure	☐	☐	High cholesterol	☐	☐	Poor circulation	☐	☐	Angina	☐	☐	Excessive bruising

D. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Asthma	☐	☐	Apnea	☐	☐	Emphysema	☐	☐	Hay fever	☐	☐	Shortness of breath	☐	☐	Pnumonia

E. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Anorexia/Bulimia	☐	☐	Ulcer	☐	☐	Food sensitivities	☐	☐	Heartburn	☐	☐	Constipation	☐	☐	Diarrhea

F. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Blurred vision	☐	☐	Ringing in the ears	☐	☐	Hearing loss	☐	☐	Chronic ear infection	☐	☐	Loss of smell	☐	☐	Loss of taste

G. Integumentary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Skin cancer	☐	☐	Psoriasis	☐	☐	Eczema	☐	☐	Acne	☐	☐	Hair loss	☐	☐	Rash

H. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Thyroid issues ☐	☐		Immune disorders	☐	☐	Hypoglycemia	☐	☐	frequent infection	☐	☐	Swollen glands	☐	☐	Low energy

I. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Kidney stones	☐	☐	Infertility	☐	☐	Bedwetting	☐	☐	Prostate issues	☐	☐	Erectile dysfunction	☐	☐	PMS symptoms

J. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		Had	Have	
☐	☐	Fainting	☐	☐	Low libido	☐	☐	Poor appetite	☐	☐	Fatigue	☐	☐	Sudden weight gain/loss	☐	☐	Weakness

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

11. Illnesses

Check the illnesses you have had in the past or have now.

Had	Have		Had	Have	
☐	☐	AIDS	☐	☐	Tuberculosis
☐	☐	Alcoholism	☐	☐	Typhoid fever
☐	☐	Allergies	☐	☐	Ulcer
☐	☐	Arteriosclerosis	☐	☐	Other: _____
☐	☐	Cancer			_____
☐	☐	Chicken pox			_____
☐	☐	Diabetes			_____
☐	☐	Epilepsy			_____
☐	☐	Glaucoma			_____
☐	☐	Goiter			_____
☐	☐	Gout			
☐	☐	Heart disease			
☐	☐	Hepatitis			
☐	☐	HIV Positive			
☐	☐	Malaria			
☐	☐	Measles			
☐	☐	Multiple Sclerosis			
☐	☐	Mumps			
☐	☐	Polio			
☐	☐	Rheumatic fever			
☐	☐	Scarlet fire			
☐	☐	STD			
☐	☐	Stroke			

12. Operations

Surgical interventions which mat or may not have included hospitalization.

☐ Appendix removal
☐ Bypass surgery
☐ Cancer
☐ Cosmetic surgery
☐ Elective surgery : _____
_____
☐ Eye surgery
☐ Hysterectomy
☐ Pacemaker
☐ Spine: _____
_____
_____
☐ Tonsillectomy
☐ Vasectomy
☐ Other: _____
_____
_____
_____

13. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**

Past	Currently	
☐	☐	Acupuncture
☐	☐	Antibiotics
☐	☐	Birth control pills
☐	☐	Blood transfusions
☐	☐	Chemotherapy
☐	☐	Chiropractic care
☐	☐	Dialysis
☐	☐	Herbs
☐	☐	Homeopathy
☐	☐	Hormone replacement
☐	☐	Inhaler
☐	☐	Massage therapy
☐	☐	Physical therapy
☐	☐	Nutritional supplements :
		_____
		_____
		_____
		_____
☐	☐	Medications:
		_____
		_____
		_____
		_____
		_____

14. Injuries

Have you ever…

☐ Had a fracture or broken bone
☐ Had a spine or nerve disorder
☐ Been knocked unconscious
☐ Been injured in an accident
☐ Used a crutch or other support
☐ Used neck or back bracing
☐ Received a tattoo
☐ Had a body piercing

15. Social history

Inform your doctor about your health habits and stress levels.

Alcohol use	☐ Daily	☐ Weekly	How much ?_____
Coffee use	☐ Daily	☐ Weekly	How much ?_____
Tobacco use	☐ Daily	☐ Weekly	How much ?_____
Exercising	☐ Daily	☐ Weekly	How much ?_____
Painkillers	☐ Daily	☐ Weekly	How much ?_____
Soda	☐ Daily	☐ Weekly	How much ? _____
Water intake	☐ Daily	☐ Weekly	How much ? _____
Recreational drugs?		☐ Yes	☐ No

Hobbies: _____

16. What is the major stressor in your life? _____

17. How many hours do you sleep on average per night? _____

18. What is your preferred sleeping position? _____

19. Describe your typical eating habits: ☐ Skip breakfast ☐ 2 meals a day ☐ 3 meals a day ☐ Snacking between meals

20.In addition to the main reason for your visit today, what additional health goals do you have?

_____

Signature _____ Initials Doctor

Date _____