Patient History Form

Name:_____ Date: _____

Address: _____

City: _____ Province:_____ Postal Code: _____

Home Telephone Number:_____ Date of Birth (DD/MM/Y):_____ Age: ___

Marital Status: _____ Spouse's Name: _____

Children:_____

Your Occupation: _____

Employer:_____

Address:_____

City: _____ Province:_____ Postal Code: _____

Closest Relative: _____ Phone Number: _____

How did you hear about our office?_____

Prior Chiropractic Care:

Name: _____ Telephone: _____

X-Rays Taken? ☐ Yes ☐ No Date: _____

Results: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Medical Doctor:

Name: _____Telephone: _____

Address: _____

Date of Last Appointment:_____Date of Last Physical:_____

Reason For Consulting This Office:

_____

_____

_____

_____

Expectations:

_____

_____

_____

Draw in your face.
Show area(s) of pain or unusual feeling.
Mark the areas on this body where you feel the described sensations. Use the appropriate symbols.
Mark areas of radiation. Include all affected areas.

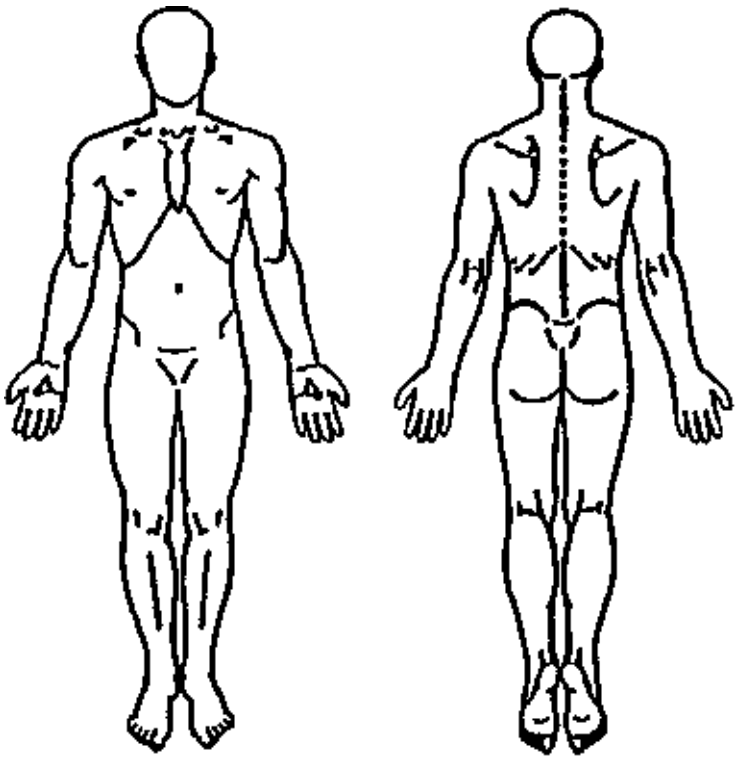
Numbness ● ● ● ● ●
● ● ● ● ●
● ● ● ● ●

Pins & Needles ○ ○ ○ ○ ○
○ ○ ○ ○ ○
○ ○ ○ ○ ○

Burning X X X X X
X X X X X
X X X X X

Aching * * * * *
* * * * *
* * * * *

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



Have you ever had any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	aneurysm	☐	☐	osteoporosis	☐	☐	diabetes
☐	☐	arthritis	☐	☐	respiratory conditions	☐	☐	epilepsy
☐	☐	cancer	☐	☐	strokes	☐	☐	allergies
☐	☐	heart conditions	☐	☐	hepatitis	☐	☐	nerves
☐	☐	fatigue	☐	☐	polio	☐	☐	sleeping difficulties
☐	☐	pneumonia	☐	☐	psoriasis	☐	☐	HIV
☐	☐	V.D.	☐	☐	sinus conditions			

Childhood conditions had, please check:

☐ measles	☐ mumps	☐ chicken pox	☐ whooping cough
☐ scarlet fever	☐ diphtheria	☐ rheumatic fever	☐ typhoid fever
☐ ear infections	☐ tubes in ears	☐ chronic illness	

Please check the appropriate box for any of the following symptoms which you now have or have had previously.
O = Occasional **F** = Frequent **C** = Constant

O	F	C	
☐	☐	☐	allergy
☐	☐	☐	chills
☐	☐	☐	convulsions
☐	☐	☐	dizziness
☐	☐	☐	fainting
☐	☐	☐	fevers
☐	☐	☐	headaches
☐	☐	☐	loss of sleep
☐	☐	☐	nervousness
☐	☐	☐	depression
☐	☐	☐	neuralgia
☐	☐	☐	numbness
☐	☐	☐	sweats
☐	☐	☐	loss of weight
☐	☐	☐	tremors

Muscle & Joint

☐	☐	☐	arthritis
☐	☐	☐	bursitis
☐	☐	☐	foot trouble
☐	☐	☐	hernia
☐	☐	☐	low back pain
☐	☐	☐	neck pain
☐	☐	☐	neck stiffness
☐	☐	☐	pain between shoulders

Respiratory

☐	☐	☐	chest pain
☐	☐	☐	chronic cough
☐	☐	☐	difficulty breathing
☐	☐	☐	spitting blood
☐	☐	☐	throat phlegm
☐	☐	☐	wheezing

Eyes, Ears, Nose & Throat

☐	☐	☐	colds
☐	☐	☐	crossed eyes
☐	☐	☐	deafness
☐	☐	☐	dental decay
☐	☐	☐	asthma
☐	☐	☐	ear aches
☐	☐	☐	ear discharges
☐	☐	☐	ear noises
☐	☐	☐	sinus infections
☐	☐	☐	enlarged glands
☐	☐	☐	enlarged thyroid
☐	☐	☐	sore throat

O	F	C	
☐	☐	☐	tonsillitis
☐	☐	☐	eye pain
☐	☐	☐	failing vision
☐	☐	☐	far sighted
☐	☐	☐	gum trouble
☐	☐	☐	hay fever
☐	☐	☐	hoarseness
☐	☐	☐	nasal obstruction
☐	☐	☐	near sighted
☐	☐	☐	nosebleeds

Cardio-Vascular

☐	☐	☐	rapid heart beat
☐	☐	☐	slow heart beat
☐	☐	☐	swelling of ankles
☐	☐	☐	hardening of arteries
☐	☐	☐	high blood pressure
☐	☐	☐	low blood pressure
☐	☐	☐	pain over heart
☐	☐	☐	poor circulation

Gastro Intestinal

☐	☐	☐	excessive hunger
☐	☐	☐	burping or gas
☐	☐	☐	liver trouble
☐	☐	☐	colitis
☐	☐	☐	colon trouble
☐	☐	☐	constipation
☐	☐	☐	diarrhea
☐	☐	☐	difficult digestion
☐	☐	☐	distension of abdomen
☐	☐	☐	stomach pain
☐	☐	☐	gall bladder trouble
☐	☐	☐	hemorrhoids
☐	☐	☐	intestinal worms
☐	☐	☐	jaundice
☐	☐	☐	poor appetite
☐	☐	☐	nausea
☐	☐	☐	vomiting
☐	☐	☐	vomit blood

Skin

☐	☐	☐	boils
☐	☐	☐	bruise easily
☐	☐	☐	dryness
☐	☐	☐	hives or allergy
☐	☐	☐	itching

O	F	C	
☐	☐	☐	skin rash
☐	☐	☐	varicose veins

Genito-Urinary

☐	☐	☐	bed wetting
☐	☐	☐	blood in urine
☐	☐	☐	frequent urination
☐	☐	☐	loss control urine
☐	☐	☐	kidney infection
☐	☐	☐	painful urination
☐	☐	☐	prostate trouble
☐	☐	☐	pus in urine
☐	☐	☐	smell of urine

Pain or Numbness in:

☐	☐	☐	shoulders
☐	☐	☐	arms
☐	☐	☐	hands
☐	☐	☐	hips
☐	☐	☐	legs
☐	☐	☐	knees
☐	☐	☐	ankles
☐	☐	☐	feet
☐	☐	☐	painful tail bone
☐	☐	☐	sciatica
☐	☐	☐	swollen joints

For Women Only:

☐	☐	☐	cramps
☐	☐	☐	heavy flow
☐	☐	☐	light flow
☐	☐	☐	irregular cycle
☐	☐	☐	painful cycle
☐	☐	☐	discharge
☐	☐	☐	sore breasts

Menopausal: ☐ Yes ☐ No
Last Menstration Date: _____

Pregnant: ☐ Yes ☐ No
Due Date: _____

Habits of Lifestyle

Do you smoke? ☐ Yes ☐ No
Do you consume alcohol? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No
Exercise Indoor Activities: _____
Exercise Outdoor Activities: _____

Rate your sleep hours per night: ☐ 4-6 ☐ 6-8 ☐ 8-10 ☐ 12+
Do you wake rested? ☐ Yes ☐ No

Rate your appetite: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent
Rate your diet: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent
Do you eat regularly: ☐ Breakfast ☐ Lunch ☐ Dinner
Do you eat per day: ☐ 1 meal ☐ 2 meals ☐ 3 meals ☐ 4 meals ☐ More than 4 meals

Date of last dental examination:_____

Falls and Accidents (please list):

_____
_____

Surgery/Operations (please list):

_____
_____

Surgery recommended but not performed (please list):

_____
_____

Do you take vitamins and minerals? ☐ Yes ☐ No List:_____

Have you ever been knocked unconscious: ☐ Yes ☐ No ☐ Don't Know If so, for how long: _____

List any medication or drugs you are currently taking: _____

_____
_____

Have you previously been hospitalized: ☐ Yes ☐ No
Please list: _____
_____

Any family health conditions: ☐ Yes ☐ No
Please list: _____
_____

_____ _____
Signature Date