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Confidential History Form

Personal Information

Name____ Gender ☐M ☐F Date____________________

Date of Birth D______M______Y_________ Age _____________ Marital Status ☐ M ☐ S ☐ W ☐ D ☐ Sep.

Address ____
City/Prov.______________ Postal Code ____________
*Please **circle** preferred contact method:*
Home Phone (_______)_______________________ Work Phone (_______)__________________Ext:______
Cell Phone (________)_______________________ Email Address _________________________________

Employer __________________________________ Type of Work _____________________
Do you have extended health coverage for chiropractic? ☐ No ☐ Yes Company:____________________________

Spouse's Name ______________________________ Spouse's Occupation ________________________________
Children's Names & Ages ____
Sibling's Names & Ages ____

Name of your Medical Doctor & city ____
Date of last physical examination ____________________ May we contact your Medical Doctor if necessary? ☐ Yes ☐ No

Have you ever been to a Chiropractor? ☐ Yes ☐ No
Name of Chiropractor & city____________________________________ Date of last visit: _____________________
Why did you discontinue care? ____

Referrals are our highest compliment; please share with us where you heard about our office:
☐ Current patient. Who? ________________________ ☐ Facebook ☐ Google/+ ☐ Other: ______________________

Current Health Information

Tell us why you are here____

Have you seen any other doctor(s)/therapists for this reason? ☐ No ☐ Yes Who? _______________________________
When did this condition begin?___________________________ Has this occurred before? ☐ No ☐ Yes
Is it getting: ☐ Worse ☐ Better ☐ Constant ☐ Comes and goes
Character of the pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning ☐ Other
Severity of your **pain** No Pain < 0 1 2 3 4 5 6 7 8 9 10 > Severe Pain

Your current level of **health** Low Health< 0 1 2 3 4 5 6 7 8 9 10 > Optimal Health

Where in your body do you hold or carry your stress? ____

How many hours do you sleep at night?_____ Do you have difficulty falling asleep? ☐ No ☐ Yes Staying asleep? ☐ No ☐ Yes

Natural supplements you currently take:

Physical Stress (list year)

☐ Motor Vehicle Accidents________________________________ ☐ Sports injuries_________________________________

☐ Work injuries____ ☐ Falls____

How many glasses of water do you consume /day ____
How many hours do you sit daily _____/day

Medications you currently take: ☐ Painkillers ☐ Muscle relaxants ☐ Blood pressure meds ☐ Heart meds
☐ Insulin ☐ for Indigestion ☐ for Depression ☐ for Anxiety
☐ for Asthma ☐ for Allergies ☐ High cholesterol ☐ ADHD/ADD
☐ Other______________________ Over the counter drugs__________________________

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

SYSTEMS REVIEW

- ☐ *Poor Attention*
- ☐ *Migraines*
- ☐ *Headaches*
- ☐ *Tight Muscles*
- ☐ *Depressed*
- ☐ *Lacking Motivation*
- ☐ *Poor Concentration*
- ☐ *Eating Disorders*
- ☐ *Constipation*
- ☐ *Cold Hands*
- ☐ *Cold Feet*
- ☐ *Bed Wetting*
- ☐ *Irritable*
- ☐ *Teeth Grinding*
- ☐ *Anxiety*
- ☐ *Heart Palpitations*
- ☐ *Poor Immune System*
- ☐ *Irritable Bowel*

HISTORY OF DISEASE

- ☐ *Cancer*
- ☐ *Rheumatoid Arthritis*
- ☐ *Diabetes*
- ☐ *Multiple Sclerosis*
- ☐ *Chronic Fatigue Syndrome*
- ☐ *Fibromyalgia*
- ☐ *ALS*
- ☐ *Epstein-Barr Syndrome*

OTHER:

IN ORDER TO SERVE YOU BETTER, PLEASE INDICATE WHETHER YOU ARE INTERESTED IN:

☐ INITIAL RELIEF CARE (GETTING OUT OF PAIN)
☐ MANAGED CARE (IMPROVING YOUR GENERAL HEALTH)

FOR DOCTOR'S USE ONLY:

Location: Intensity:

Onset: Duration:

Radiation: Frequency:

Character: Aggravating factors:

Relieving factors: Associated symptoms: