taylor creek CHIROPRACTIC

Confidential Health History Form
ADULT

Name:		**Cell Phone:**
Address:		**Home Phone:**
City:	**Prov:**	**Work Phone:**
Postal Code:	**Gender: F / M / O**	**Birth Date:** D/M/Y **Age:**
Email:		**Spouse/Partner Name:**
Occupation:		**Spouse/Partner Phone:**
Business/ Employer:		**Spouse Employer:**

Emergency Contact Name & Phone:

Health Insurance Company & coverage amount/year:

Name of Family Doctor:	**Date of last physical:**

First name and age of your kids:

List Exercises - Hobbies - Interests:

Would you like appointment reminders by: ☐ **EMAIL** ☐ **SMS(text)** ☐ **Phone** ☐ **No reminders necessary**

How did you hear about our office? _____

Have you had previous Chiropractic care? ☐ No ☐ Yes If yes, when was your last visit: _____

Indicate your primary symptom: _____

Is your symptom due to an accident? ☐ No ☐ Yes Type of Accident: ☐ Auto ☐ Work ☐ Other

When did your symptom begin? _____ **Have you had this symptom before?** ☐ No ☐ Yes

What do you think caused your symptom? _____

Have you had previous treatment for this symptom? ☐ No ☐ Yes, specify _____

Have you had X-ray, MRI or other tests for this symptom? ☐ No ☐ Yes, specify: _____

Does this symptom interfere with your: ☐ work ☐ sleep ☐ personal life ☐ mood ☐ activities ☐ other

Rate the intensity of your symptom **1 2 3 4 5 6 7 8 9 10**

Least pain **Worse pain**

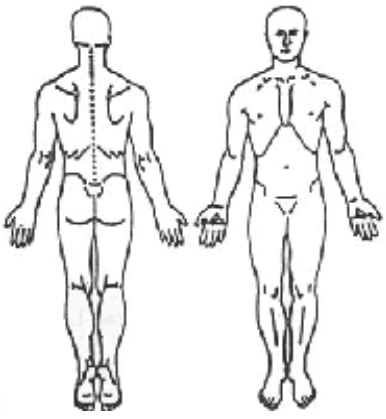
Is your symptom: ☐ **Constant** ☐ **Occasional** **Worse** ☐ **in the morning** ☐ **at night**

What aggravates your symptom? _____

What relieves your symptom? _____

Indicate on the diagram (to the right): **S** for **SHARP** Pain **D** for **DULL** pain

T for **TINGLING/NUMBNESS** **B** for **BURNING / THROBBING** **A** for **ACHING** pain



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Please ☑ check the following boxes: "C" for the conditions you are CURRENTLY experiencing and under the "P" for conditions you have had in the PAST ** the *last few rows in italics are for WOMEN only* **

	C | P		C | P		C | P		C | P
Unexplained weight loss	☐|☐	Slurred speech	☐|☐	Poor appetite	☐|☐	Headaches	☐|☐
Unrelenting pain (day or night)	☐|☐	Previous stroke/ TIA	☐	Fever / chills/ sweats	☐|☐	Jaw pain	☐|☐
Loss of bowel/bladder function	☐|☐	Double vision	☐|☐	Frequent colds	☐|☐	Sinus pain	☐|☐
Loss of balance/ feel unstable	☐|☐	Heart palpitations	☐|☐	Anxiety/ depression	☐|☐	Neck pain	☐|☐
Poor concentration or memory	☐|☐	Fainting / dizziness	☐|☐	Heartburn/indigestion	☐|☐	Upper/Mid Back	☐|☐
Ringing in the ears / tinnitus	☐|☐	Angina/ chest pain	☐|☐	Constipation/Diarrhea	☐|☐	Shoulder pain	☐|☐
Spitting up blood/ phlegm	☐|☐	High blood pressure	☐|☐	Irritable bowel	☐|☐	Wrist/hand pain	☐|☐
Difficulty swallowing	☐|☐	Low blood pressure	☐|☐	Nausea / vomiting	☐|☐	Low Back pain	☐|☐
Varicose veins/ phlebitis/clots	☐|☐	Tremors	☐|☐	Asthma	☐|☐	Hip/Groin pain	☐|☐
Blood in stool / urine	☐|☐	Difficulty breathing	☐|☐	Ear infection	☐|☐	Knee pain	☐|☐
Painful urination	☐|☐	Chronic cough	☐|☐	Difficulty sleeping	☐|☐	Ankle/arch pain	☐|☐
Cold/ swollen hands or feet	☐|☐	Bronchitis	☐|☐	Pneumonia	☐|☐	Migraines	☐|☐
Menstrual pain	☐|☐	*Hot flashes*	☐|☐	*Weight gain*	☐|☐	*Weight loss*	☐|☐
Mood swings	☐|☐	*Irregular cycles*	☐|☐	***If Pregnant due date***			

Indicate any other conditions of concern: _____

Please check ☑ what applies to you

Prolonged sitting/ desk work	☐	Repetitive lifting	☐	Prolonged standing	☐	Repetitive twisting	☐
Emotional stress	☐	Poor posture	☐	Lack of sleep	☐	Stomach sleep	☐
As a child fell /jumped from a height greater than 4 ft (e.g. play structure)	☐	**As a child** had impacts snowboarding/ skiing/ biking /trampoline etc.…	☐	**As a child** played contact sports	☐	**As a child** sustained other traumas	☐
History of concussion	☐	Fractured a bone	☐	Received stitches	☐	Had surgery	☐
Had a work injury	☐	Repetitive type injury	☐	Had a serious fall	☐	Chronic stress	☐
Had a car accident	☐	Went to Emergency	☐	Cancer diagnosis	☐	Have HIV	☐

Describe any major trauma or impact: _____

List any diagnosed condition(s): _____

List any medication you are currently taking: _____

List intake

Coffee _____/ day	Caffeinated drinks:_____/day	Glasses of water:_____/day	Alcohol:_____/day _____/week
Cigarettes _____/day	Hours of sleep:_____/night	Hours of driving:_____/day	Hours of sitting _____/day

The fee for the New Patient Consultation and examination is 110$. X-ray digital imaging if required is 40$ - 80$.

Signature: _____ **Date**: _____