Confidential Health Concern History

Personal Information: Date:_____

Last Name: _____ First Name: _____

Address: _____ City: _____ P.C. : _____

Home Phone: _____ Cell: _____ Work: _____

Birth Date m/___ d/___ y/____Occupation: _____ Employer _____

Care Card Number: _____ Family Physician: _____

Spouse Name: _____Names/ages of children: _____

Who may we thank for your referral to our office? _____

Email address (for appointment reminders): _____

Health Information:

What are your objectives in consulting our office? _____

What are your health goals once these objectives have been met? _____

_____

Who was the last Dr. who created a Health Development Plan for you? _____

Did you follow the Dr.'s recommendations? ❑ Yes ❑ No

What were your results? _____

What other wellness professionals are currently a part of your health care team?

❑ Massage Therapist ❑ Acupuncturist ❑ Naturopath ❑ Homeopath ❑ Other _____

How many Medical Doctor's office visits did you have last year?

❑ None ❑ Less than 5 ❑ More than 5 ❑ More than 10

Have you had previous Chiropractic Care ❑ Yes ❑ No Dr.'s Name: _____

List previous surgeries and dates: _____

Medications: ❑ Pain ❑ Anti-inflam ❑ Heart ❑ Other: _____

Lifestyle Information:

Do you exercise? ❑ Yes ❑ No If yes, how much and how often? _____

Do you smoke? ❑ Yes ❑ No If yes, how much? _____

Do you consume alcohol? ❑ Yes ❑ No If yes, how much and how often? _____

Do you drink water? ❑ Yes ❑ No If yes, how much per day? _____

Health History:

Please check all of the following health concerns that you have experienced, even if you do not think your answers relate to your present health concern.

- ❑ Allergies
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Back pain
- ❑ Bladder problems
- ❑ Cancer
- ❑ Depression
- ❑ Diarrhea
- ❑ Digestive problems
- ❑ Dizziness
- ❑ Headaches
- ❑ Heartburn/Reflux
- ❑ Heart Condition
- ❑ Immune System Disorder
- ❑ Kidney Disease
- ❑ Menstrual Cramps
- ❑ Mood swings
- ❑ Neck Pain
- ❑ Numbness/Tingling
- ❑ Osteoporosis
- ❑ Sinus Trouble
- ❑ Skin Conditions
- ❑ Urinary Difficulty
- ❑ Vertigo
- ❑ Other _____

_____

_____

Stress History:

Please indicate whether you have **ever** experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to your present health concerns.

1) Childhood

- ❑ Repeated/Prolonged Antibiotic Use
- ❑ Car Accident
- ❑ Childhood Illness
- ❑ Fall/Jump from a Height < 3 feet
- ❑ Fall/Jump from a Height > 3 feet
- ❑ Head Trauma
- ❑ Inhaler Use
- ❑ Prescription Medications
- ❑ Surgery
- ❑ Vaccination
- ❑ Youth Sports
- ❑ Other Traumas* (Physical or Emotional)

*please describe:_____

2) Adulthood

- ❑ Alcohol Consumption
- ❑ Repeated/Prolonged Antibiotic Use
- ❑ Car Accident
- ❑ Coffee Drinker
- ❑ Drug Use/Abuse
- ❑ Fall/Jump from a Height
- ❑ Head Trauma
- ❑ Home Environment Stress*
- ❑ Inhaler Use
- ❑ Prescription Medications
- ❑ Smoker
- ❑ Surgery
- ❑ Contact Sports
- ❑ Extreme Sports
- ❑ Other Traumas* (Physical or Emotional)

*please describe:_____

Which best describes your reason for consulting our office?

- ❑ I have a specific concern and require help only with this concern.
- ❑ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.
- ❑ I want to be healthier 5 years from now than I am today.