Absolute Chiropractic Wellness Centre

3774 Walker Road
Windsor, Ontario N8W 3S8
T: (519) 967-8592
F: (519) 967-8595

# Confidential Patient Health History Form

Name: ______________________________________________ Sex: ☐ Female ☐ Male

Address: ________________________________ City: ____________ Postal Code:__________

H. Phone ______________________ W. Phone ______________________ Ext.: __________

Date of Birth: _____/______/______ Age: ______ Email ________________________________
yr mm dd

Employer: ______________________________ Occupation: ____________________________

Medical Doctor: _________________________ Contact Person: ____________________________

Spouse's name: ________________________________________________________________

Have you ever received Chiropractic care? ☐ Yes ☐ No If yes, where:_________________________

Do you have Extended Health Benefits? ☐ Yes ☐ No

Is this a Work Related Injury? ☐ Yes ☐ No Motor Vehicle Accident? ☐ Yes ☐ No

Referred By: ____________________________________________________

## About Your Health

Please select your goal for your Chiropractic Treatment

☐ Pain or crisis care (4-6 weeks) ☐ Corrective Care (3-6 months)

☐ **I am *also* interested in ongoing maintenance care once the problem had been helped.**

☐ **I am interested in chiropractic care for my family and/or my children**

**Is there a family history of:**

| | Heart Disease | Stroke | Cancer | Arthritis | Diabetes | Other | |
|---|---|---|---|---|---|---|---|
| Mother's Side | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ________ |
| Father's Side | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ________ |

Please list all medications and supplements you are currently taking:

1. ____________________ 3. ____________________ 5. ____________________

2. ____________________ 4. ____________________ 6. ____________________

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**Name:**________________________________

### Symptoms/Health Concerns

If you have a specific chief complaint, please describe briefly.

1.________________________________________________________________

How and when did this problem start? ____________________________________________

Does the pain radiate or travel anywhere else? ______________________________________

Is the problem… ☐ constant ☐ intermittent ☐ worse with movement

Is condition worse… ☐ in the A.M. ☐ in the P.M. ☐ no change

Is the condition interfering with…☐ sleep ☐ work ☐ routine ☐ other ____________________

Is condition getting progressively worse? ☐ Yes ☐ No

Is the Pain: ☐ sharp ☐ dull ☐ throbbing ☐ aching ☐ shooting ☐ other __________

Since the Pain started have you experienced: ☐ Fever ☐ Bowel or Bladder Problems ☐ Weight Loss/Gain

What aggravates your condition / pain? ______________________________________________

What relieves your condition / pain? ________________________________________________

If your condition was treated in the past, please describe treatment and results. __________________________

________________________________________________________________

Have you had X-rays, Ultrasounds, MRI's, CT's taken of this area? ☐ Yes ☐ No Clinic Location: ______________

Additional Complaints

2.________________________________________________________________

3.________________________________________________________________

**Chiropractic has been shown to help with the following, please mark if you would like help with:**

__ Asthma
__ Allergies
__ Bulge Disc
__ Bloating
__ Bed Wetting (Enuresis)
__ Constipation
__ Carpal Tunnel
__ Colic
__ Digestive Problems
__ Dizziness
__ Diarrhea
__ Ear Infections

__ Fatigue
__ Heartburn or Pyrosis
__ Headaches
__ Low back pain
__ Migraines
__ Muscle Injuries
__ Neck Pain
__ Numbness
__ Osteoarthritis
__ Pain
__ Poor Immune System
__ Sinus Infections

__ Sinus Headaches
__ Sleeping Problems
__ Scoliosis
__ Shoulder Injury/ Pain
__ Sciatica
__ Tingling
__ Vertigo
__ Other____________
____________________
____________________
____________________
____________________

Please list all surgeries and the dates you had them:

1. ______________________________ 2. ______________________________

3. ______________________________ 4. ______________________________

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**Name:** ______________________

# HEALTH HISTORY

**Place A Checkmark If You Have Had Any of The Following:**

__Alcoholism
__Allergies
______________________
______________________
__Anemia
__Anorexia
__Arm Pain
__Arthritis
__Asthma
__Bladder Problems
__Bloating
__Bronchitis
__Bulge, Herniated Disk
__Cancer
__Cataracts
__Chemical Dependency
__Crohn's
__Chronic Constipation
__Chronic Fatigue Syndrome
__Chronic Throat Infections

__Depression
__Diabetes
__Difficulty Breathing
__Dizziness
__Emphysema
__Epilepsy
__Fatigue
__Fibromyalgia
__Gallbladder Conditions
__Gastritis
__Glaucoma
__Goiter
__Gout
__Headaches
__Head Colds
__Heart Attack
__ Heart Condition
__ Heart Burn or Pyrosis
__ Hepatitis
__ High Blood Pressure
__High Cholesterol Levels

__Indigestion
__Insomnia
__Irritable Bowl Syndrome
__Jaundice or Liver Condition
__Kidney Problems
__Liver Disease
__Low Back Pain
__Measles
__Menstrual Cramps or Problems
__Middle Back Pain
__Migraine Headaches
__Mononucleosis
__Multiple Sclerosis
__Numbness
__Osteoarthritis
__Osteoporosis
__Pinched Nerve
__Pneumonia

__Polio
__Prostate Problems
__Rheumatoid Arthritis
__Shortness of Breath
__Sinus Headaches/Infection
__Scarlet Fever
__Sleep Apnea
__Sleeping Problems
__Stiff Neck
__Stomach Problems/Ulcers
__Stroke
__Tingling
__Thyroid
__Tonsillitis
__Tuberculosis
__Tumors
__Ulcerative Colitis
__Vertigo
__Whooping Cough
Other ______________________
______________________

**Events and Habits**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Ever in a motor vehicle accident? Injuries ____________________ Treatments_________________________ |
| ☐ | ☐ | Any notable falls or injuries? ____________________ |
| ☐ | ☐ | Hobby or sports injuries? ____________________ |
| ☐ | ☐ | Smoke __________ packs/day Alcohol ___________ drinks/week |
| ☐ | ☐ | Exercise? ☐ Daily ☐ Weekends ☐ Sporadically ____________________ |
| ☐ | ☐ | Proper posture? ____________________ |
| ☐ | ☐ | Eat as healthy as you think you should? ____________________ |
| ☐ | ☐ | Do you use Artificial Sweeteners, drink Diet Sodas? |
| ☐ | ☐ | Are you or have you ever been overweight? ____________________ |
| ☐ | ☐ | Occupational stress? ____________________ |
| ☐ | ☐ | Physical stress? ____________________ |
| ☐ | ☐ | Mental stress? ____________________ |

Sleep posture - ☐ side ☐ back ☐ stomach Number of Pillows _____________

Sleep surface - ☐ mattress ☐ water bed Approximate Age of Mattress _____

**Consent for Examination:** ______________________________________________ **(Patient Signature)**