CONFIDENTIAL PATIENT HEALTH HISTORY

Name ______________________ Age ______ Birth date (DD/MM/YY) ______________

Address ______________________ City ______________ Postal Code ______________

Cell ______________ Home phone ______________ Email ______________________

Twitter @______________ Occupation ______________ Whom may we thank for referring you? ______________

Marital Status ______ Spouse's Name ______________ Children's Names and Ages ______________________

Have you had previous Chiropractic and/or Acupuncture care? ______ When? (Include last visit date) ______________

Where? (Include Dr's Name) ______________________

Why? ______________________

Were X-rays taken? (Include date) ______________________

Main reason for consulting this office: ______________________

Other health concerns: ______________________

How long have you had this condition? ______________ Have you had this or similar conditions in the past? ______________

What activities aggravate your condition? ______________________

Is this condition getting progressively worse? (Circle) . . . Yes No Constant Comes and goes

Is this condition interfering with your (Circle) . . . Work Sleep Daily routine Other ______________

How long has it been since you really felt good? ______________________

Other Doctors/Therapists who have treated this condition ______________________

Medical Doctor's name (Include last visit date & reason) ______________________

List surgical procedures and dates: ______________________

List any diagnosed medical conditions: (eg. Diabetes, Arthritis, Cancer, etc) ______________________

Drugs you now take (Circle): Allergy / Inhaler Anti-inflammatory Anti-depressant Blood Pressure Heart pill Cholesterol pill Hormone Replacement pill Insulin Thyroid pill Birth control pill Other ______________________

Have you experienced any adverse effects? (eg. Indigestion, Constipation, etc) ______________________

Do you have a lot of stress in your life lately? ______________ Do you get enough sleep regularly? ______________

Approximate age of mattress ______________ Is it comfortable? ______________ Are your pillows comfortable? ______________

Do you wear (Circle) . . . . Custom Prescribed Orthotics Heel/Sole lifts Arch supports/Inner soles

What type of regular exercise do you do? ______________________

How much water do you drink daily? ______________ Do you eat well balanced meals regularly? ______________

How much coffee do you drink daily? ______________ Do you smoke? (How much daily) ______________

Have you ever been in an auto accident? (Circle) . . . . Past year Past 5 years Over 5 years Never

Describe: ______________________

Have you ever had any other personal injuries or accidents? (Circle) . . . . Past year Past 5 years Over 5 years Never

Describe: ______________________

What is your health goal? (Please circle one)

1. RELIEF CARE: Only relieves the pain and symptoms.
2. CORRECTIVE CARE: Addresses the cause of the problem as well as reduces the pain and symptoms.
3. WELLNESS CARE: Corrects the cause of the problem as well as allows the body to function to its maximum health potential.

Do you (or your spouse) have Extended Health Care Insurance? ______________ Yearly limit amount: ______________

Is this a Motor Vehicle Accident case? ______________ Is this a Worker's Compensation case? ______________

I understand I will be solely responsible for any and all fees:

______________ ______________________

DATE PATIENT SIGNATURE (or Guardian)

HealthForLifeFamilyChiro.com
2470 Felhaber Cres, Oakville, ON, L6H 7R8
c. 647.883.1885 t. @HFLfamilychiro