



Confidential Adult and Adolescent (13+) History Form

Please take a few moments to complete this form. Your answers will help us to determine if we can accept your case. If we sincerely believe that your condition will respond more favourably with another health care provider, we will be happy to refer you. If you need help with this form, please do not hesitate to ask our Chiropractic Health Assistants Nancy, Carri, Nicole or Erin. THANK YOU.

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 _____

Home Phone (_____) _____ Best time to reach you at home? _____

Email Address _____

I AGREE to receive doctor and office correspondence, and my email will not be shared with anyone outside of this office)

Occupation _____ Employer _____

Business Phone (_____) _____ Ext: _____ May we call you at work? No Yes

Is this a motor vehicle accident (MVA) case? No Yes Date of accident: _____

Is this a WSIB case? No Yes has the accident been reported at work? No Yes

Spouse's Name _____ Spouse's Occupation _____

Children's Names & Ages _____

Referrals are our highest compliment; please share with us where you heard about our office:

Current patient – who? _____ Yellow Pages Beacon Phonebook

Online Yellowpages.com Our Website Google/Online search

Other - please specify _____

Reason for consulting this office:

Wellness Prevention Symptom Relief

Current Health Information

Name of your Medical Doctor & city _____

Date of last physical examination _____

Is your primary reason for being here a Wellness Check? (Circle one) Yes No

If No, What is the area of your primary complaint/reason for being here? _____

When did this problem begin? _____

Has this occurred before? Yes No Please describe when _____How often does it happen? Constant Daily Few times per week Few times per month OtherDescribe the pain: Sharp Dull Ache Pins & Needles Numb Burning Other _____

On a scale of 1-10 please circle the number representing the severity of your pain:

NO PAIN < 1 2 3 4 5 6 7 8 9 10 > SEVERE PAIN

Is it getting: Worse Better Constant Comes and goesDo you feel that this problem travels to other areas? Right arm/hand Left arm/hand Right leg/foot Left leg/foot Other (please describe) _____What aggravates your condition? Sitting Standing Bending Lifting Walking
 Sleeping Weather changes Other _____What relieves your condition? Ice Heat Massage Stretches
 Bed Rest Walking Medications Other _____

Are there other areas of concern in your body? _____

Other doctors/therapists seen for these conditions? No Yes Who? _____ When? _____**How does this problem affect your life with respect to:**

Your ability to work? _____

Your ability to enjoy your family/social time? _____

Your ability to enjoy activities/sports? _____

Medications you currently take: Painkillers Muscle relaxants Blood pressure meds Heart meds Insulin for Indigestion for Depression for Anxiety for Asthma for Allergies HRT Other _____ Over the counter drugs _____**Natural supplements you currently take:** Multivitamin B-complex vitamins Vitamin C Calcium Omega 3/6/9 Prenatal vitamin Folic acid Glucosamine Homeopathic remedies Other _____**What is your personal satisfaction with your diet?** Satisfied Dissatisfied Highly dissatisfied Why? _____**Do you have a regular exercise program?** No Yes What type and how often? _____**Do you smoke?** No Yes How much for how long? _____**Do you suffer from any other health conditions?** No Diabetes Heart Condition Hypertension Cancer Respiratory Condition _____ Digestive Condition _____ Osteoporosis Other _____

Dr. Mike Chambers | Dr. Tanya Chambers | Dr. Pip Penrose | Dr. Blair Neely



The following is a list of conditions, which may seem unrelated to your current complaint. However, we would like to assess your full health picture. Please check if you **recently** have had any of the following:

- | | | | |
|---|--|---|---|
| <i>Musculoskeletal</i> | <i>Cardiovascular/Respiratory</i> | <i>Gastro-Intestinal</i> | <input type="checkbox"/> Fibroids/cysts |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Frequent nausea | <input type="checkbox"/> Difficult delivery of baby |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Epidural |
| <input type="checkbox"/> Arm pain | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Constipation | <input type="checkbox"/> C-section surgery |
| <input type="checkbox"/> Leg pain | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Bloating/Gas | <i>General</i> |
| <input type="checkbox"/> Joint pain/stiffness | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Abdominal cramps | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Jaw pain/clicking | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Irritability |
| <i>Nervous system</i> | <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Numbness in arm/hand | <input type="checkbox"/> Stroke | <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Poor sleep |
| <input type="checkbox"/> Numbness in leg/foot | <i>Eyes/Ears/Nose/Throat</i> | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Poor balance |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Painful/excess urination | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of smell | <i>Male/Female Reproductive</i> | <input type="checkbox"/> High stress |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Earache/infection | <input type="checkbox"/> PMS | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Sinus congestion | <input type="checkbox"/> Breast pain/lumps | |

Past Health History

Please check off any hospitalizations or surgical operations and state years:

- Appendectomy_____ Tonsillectomy_____ Gall Bladder_____ Hernia_____
- Hysterectomy_____ Back Surgery_____ Broken bones_____
- Labour and Delivery_____ Other hospitalizations/surgeries_____

Please check off any previous traumas and years:

- Motor Vehicle Accidents_____ Sports injuries_____
- Work injuries_____ Falls_____
- Childhood traumas_____ Birth injuries_____

Was your own birth: C-section Forceps delivery Breech Difficult delivery

Have you ever been to a Chiropractor before? No Yes

Name of previous Chiropractor & city _____

Approximate date of last visit: _____

Have you had any x-rays taken in the past 5 years? No Yes Of what area(s)? _____

Please check off any other tests and dates: MRI _____ CT scan _____ Bone Density _____ Bone Scan _____

Other _____

Family Health History

Does any member of your family suffer from the same condition as you have now? No Yes Whom? _____

Do you have a family history of any of the following conditions? Heart disease Arthritis Osteoporosis

Cancer Diabetes Hypertension Stroke Obesity Other _____

Have your children ever had a spinal check-up? No Yes Doctor's name and when _____

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Consent for Examination

Today’s appointment will include a **Consultation** and **Examination** with one of the doctors. The purpose of this examination is to determine the cause of any health problems that you may be experiencing. We will then determine the best course of treatment for your individual case. The examination may include but not be limited to a postural assessment, range of motion testing of various areas of your spine and extremities, various orthopedic and neurological tests, and a chiropractic spinal exam. The chiropractic examination is a “hands-on” approach so that we can best assess your health. The examination may also include a computerized sEMG analysis, a gait scan analysis, as well as necessary x-rays if indicated.

Congratulations again on seeking chiropractic care!

| | | |
|--------------------------|--|------|
| Practice Member name | Practice Member Signature (or Parent Signature if Patient is under 16 years of age) | Date |
| Doctor Witness Signature | | |

For Women ONLY
Consent for x-rays

This is to certify, to the best of my knowledge, that I am **NOT** pregnant and Dr. Mike Chambers, Dr. Tanya Chambers, Dr. Pip Penrose & Dr. Blair Neely has my permission to take x-rays.

For contraception, I am presently using (check all that apply):

Birth control pills IUD Other

OR

Day 1 of my menstrual cycle was less than 10 days ago

OR

Not sexually active Menopausal

| | |
|---|------|
| Practice Member Signature (or parent/guardian if patient is under 16 years of age) | Date |
|---|------|

Doctor Witness Signature

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