STRATFORD
Chiropractic
&Wellness
CENTRE

Dr. Mike Chambers | Dr. Tanya Chambers | Dr. Pip Penrose | Dr. Blair Neely
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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 Carolyn, Nancy, Julie, Shelley or Chloe. 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 ☐ Other
Describe 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 goes
Do 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 towork?_____
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 _____

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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:

Musculoskeletal
- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Headaches
- ☐ Arm pain
- ☐ Leg pain
- ☐ Joint pain/stiffness
- ☐ Jaw pain/clicking

Nervous system
- ☐ Numbness in arm/hand
- ☐ Numbness in leg/foot
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Anxiety
- ☐ Depression
- ☐ Fainting
- ☐ Convulsions

Cardiovascular/Respiratory
- ☐ Cold hands/feet
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Heart problems
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma
- ☐ Stroke

Eyes/Ears/Nose/Throat
- ☐ Vision problems
- ☐ Loss of smell
- ☐ Dental problems
- ☐ Sore throat
- ☐ Earache/infection
- ☐ Hearing loss
- ☐ Sinus congestion

Gastro-Intestinal
- ☐ Poor appetite
- ☐ Excessive thirst
- ☐ Frequent nausea
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating/Gas
- ☐ Abdominal cramps
- ☐ Heartburn
- ☐ Liver problems
- ☐ Bladder problems
- ☐ Kidney problems
- ☐ Painful/excess urination

Male/Female Reproductive
- ☐ Prostate problems
- ☐ Menstrual pain
- ☐ PMS
- ☐ Menstrual irregularity
- ☐ Breast pain/lumps
- ☐ Fibroids/cysts
- ☐ Infertility
- ☐ Miscarriage
- ☐ Difficult delivery of baby
- ☐ Epidural
- ☐ C-section surgery

General
- ☐ Fatigue
- ☐ Irritability
- ☐ Allergies
- ☐ Poor sleep
- ☐ Poor balance
- ☐ Poor concentration
- ☐ High stress
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Frequent colds

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_____

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!

_____ _____ _____

Patient name Patient Signature Date

(or Parent Signature if Patient is under 16 years of age)

_____

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

_____ _____

Patient Signature Date

(or parent/guardian if patient is under 16 years of age)

_____

Doctor Witness Signature

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