Confidential Health Record

File # ____________

Today's Date: MM / DD / YEAR

Whom may we thank for referring you to our office? NAME ____________

○ Google ○ Walk-in ○ Word of mouth ○ Other ____________

Is this a motor vehicle accident claim? ○ Yes ○ No **Is this a workers compensation board claim?** ○ Yes ○ No

Personal Information

Name FIRST ____________ LAST ____________ **Sex** ○ Male ○ Female

Address ____________ CITY ____________ PROV ______ POSTAL CODE ____________

Email Address ____________

Phone # HOME ____________ CELL ____________ WORK ____________

Marital Status ○ Single ○ Married ○ Widowed ○ Divorced ○ Separated ○ Common Law

Birth Date YYYY/MM/DD ______/______/______ **Age** ______ **Alberta Health Care #** ____________

Spouse/Partner Name FIRST ____________ LAST ____________ ○ Not Applicable

# of Children IF APPLICABLE ______ **Names and Ages** ____________

Occupation ____________ **Employer** ____________

Hobbies/Recreation/Likes ____________

Emergency Contact

Name FIRST ____________ LAST ____________ **Relationship** ○ Spouse ○ Relative ○ Friend

Phone # HOME ____________ CELL ____________ WORK ____________

Current Health Professionals

Medical Doctor NAME ____________ PHONE ____________

ADDRESS ____________ CITY ____________ PROV ______ POSTAL CODE ____________

Dentist NAME ____________ PHONE ____________

ADDRESS ____________ CITY ____________ PROV ______ POSTAL CODE ____________

Other NAME ____________ PHONE ____________

ADDRESS ____________ CITY ____________ PROV ______ POSTAL CODE ____________

Headaches/Migraines

Do you get headaches or migraines? ○ no ○ yes **Describe:** ____________________

When/how did they start? ____________________ **Have they occurred before?** ○ no ○ yes **When?** __________

Severity: 0 (BEST) **- 10** (WORST) ________ **How often do you get them?** ____________ **How long do they last?** ____________

Location(s): ____________________ **Triggers for the headache/migraine?** ____________________

Quality: ○ dull/aching ○ sharp ○ nagging ○ stabbing ○ throbbing ○ pressure ○ other ____________

Timing: ○ all day ○ morning ○ evening ○ with activity ○ wake up with ○ seasonal ○ menstrual cycle ○ weather

Other Symptoms: ○ muscle tension ○ light/sound sensitivity ○ sinus ○ aura ○ eye strain ○ nausea ○ vomitting

The headaches/migraines are: ○ getting worse ○ getting better ○ staying the same ○ coming and going

What makes it better? ____________________ **What makes it worse?** ____________________

What care have you received? ____________________ **Was it helpful?** ○ yes ○ no

Dr. notes: ____

Neck Area

Do you have neck pain/discomfort? ○ no ○ yes **Describe:** ____________________

When/how did it start? ____________________ **Has it occurred before?** ○ yes ○ no **When?** __________

Severity: 0 (BEST) **- 10** (WORST) ________ **How often do you get it?** ____________ **How long does it last?** ____________

Quality: ○ dull/aching ○ sharp ○ burning ○ decreased rom ○ stiff/stuck ○ electric ○ other ____________

Radiating pain? ○ no ○ yes WHERE ____________ **Numbness or tingling?** ○ no ○ yes WHERE ____________

Timing: ○ all day ○ morning ○ evening ○ with activity ○ wake up with ○ other ____________

This condition is: ○ getting worse ○ getting better ○ staying the same ○ coming and going

What makes it better? ____________________ **What makes it worse?** ____________________

What care have you received? ____________________ **Was it helpful?** ○ yes ○ no

Dr. notes: ____

Upper Extremity Area (SHOULDERS, ARMS, HANDS)

Do you have any upper extremity pain/discomfort? ○ no ○ yes **Describe:** ____________________

When/how did it start? ____________________ **Has it occurred before?** ○ yes ○ no **When?** __________

Severity: 0 (BEST) **- 10** (WORST) ________ **How often do you get it?** ____________ **How long does it last?** ____________

Quality: ○ dull/aching ○ sharp ○ burning ○ decreased rom ○ stiff/stuck ○ electric ○ other ____________

Timing: ○ all day ○ morning ○ evening ○ with activity ○ wake up with ○ other ____________

This condition is: ○ getting worse ○ getting better ○ staying the same ○ coming and going

What makes it better? ____________________ **What makes it worse?** ____________________

What care have you received? ____________________ **Was it helpful?** ○ yes ○ no

Dr. notes: ____

Mid-back Area (CHEST, RIBS, MID-BACK)

Do you have any mid-back pain or discomfort? ○ no ○ yes **Describe:** ____________________

When/how did it start? ____________________ **Has it occurred before?** ○ yes ○ no **When?** __________

Severity: 0 (BEST) **- 10** (WORST) ________ **How often do you get it?** ____________________ **How long does it last?** __________

Quality: ○ dull/aching ○ sharp ○ burning ○ decreased rom ○ stiff/stuck ○ electric ○ other ____________________

Timing: ○ all day ○ morning ○ evening ○ with activity ○ wake up with ○ other ____________________

This condition is: ○ getting worse ○ getting better ○ staying the same ○ coming and going

What makes it better? ____________________ **What makes it worse?** ____________________

What care have you received? ____________________ **Was it helpful?** ○ yes ○ no

Dr. notes: ____

Low-back Area

Do you have low back pain or discomfort? ○ no ○ yes **Describe:** ____________________

When/how did it start? ____________________ **Has it occurred before?** ○ yes ○ no **When?** __________

Severity: 0 (BEST) **- 10** (WORST) ________ **How often do you get it?** ____________________ **How long does it last?** __________

Quality: ○ dull/aching ○ sharp ○ burning ○ decreased rom ○ stiff/stuck ○ electric ○ other ____________________

Radiating pain? ○ no ○ yes WHERE ____________________ **Numbness or tingling?** ○ no ○ yes WHERE ____________________

Timing: ○ all day ○ morning ○ evening ○ with activity ○ wake up with ○ other ____________________

This condition is: ○ getting worse ○ getting better ○ staying the same ○ coming and going

What makes it better? ____________________ **What makes it worse?** ____________________

What care have you received? ____________________ **Was it helpful?** ○ yes ○ no

Dr. notes: ____

Lower Extremity Area (HIPS, LEGS, KNEES, FEET)

Do you have any lower extremity pain or discomfort? ○ no ○ yes **Describe:** ____________________

When/how did it start? ____________________ **Has it occurred before?** ○ yes ○ no **When?** __________

Severity: 0 (BEST) **- 10** (WORST) ________ **How often do you get it?** ____________________ **How long does it last?** __________

Quality: ○ dull/aching ○ sharp ○ burning ○ decreased rom ○ stiff/stuck ○ electric ○ other ____________________

Timing: ○ all day ○ morning ○ evening ○ with activity ○ wake up with ○ other ____________________

This condition is: ○ getting worse ○ getting better ○ staying the same ○ coming and going

What makes it better? ____________________ **What makes it worse?** ____________________

What care have you received? ____________________ **Was it helpful?** ○ yes ○ no

Dr. notes: ____

Other Problem Areas

Describe: ______________________________

When/how did it start? ____________________ **Has it occurred before?** ● yes ● no **When?** ____________

Severity: 0 (BEST) **- 10** (WORST) ________ **How often do you get it?** ____________ **How long does it last?** ____________

Quality: ● dull/aching ● sharp ● burning ● decreased rom ● stiff/stuck ● electric ● other ____________

Radiating pain? ● no ● yes WHERE ____________ **Numbness or tingling?** ● no ● yes WHERE ____________

Timing: ● all day ● morning ● evening ● with activity ● wake up with ● other ____________

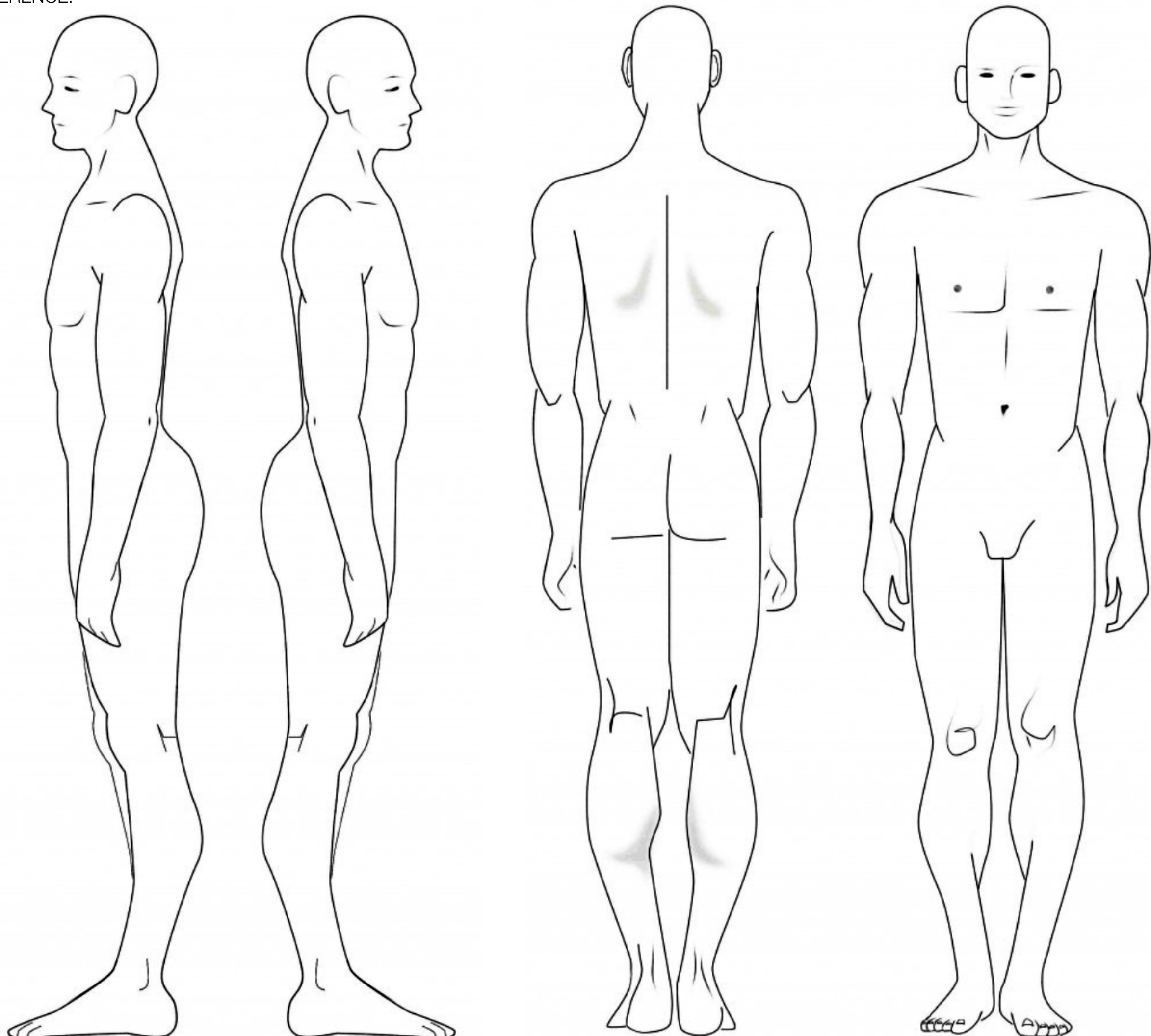
This condition is: ● getting worse ● getting better ● staying the same ● coming and going

What makes it better? ____________ **What makes it worse?** ____________

What care have you received? ____________ **Was it helpful?** ● yes ● no

Dr. notes: ______________________________

FOR DOCTOR REFERENCE:



Occupation Impact

What are the repetitive activities you do each day?: ● Lifting ● Computer ● Grasping ● Hand Tools ● Machinery ● Phone ● In/out of vehicle ● Other ______

What are your conditions interfering with?: ● Work ● Sleep ● Family Life ● Personal Life ● Hobbies ● Sports

How is your job performance affected? ● No effect ● Minor ● Limited ● Unable to Perform

Work hours per day ______ **Sitting hours per day** ______ **Heavy labour hours per day** ______

Current Lifestyle Choices

Cardio exercise ● Never ● 1x/wk ● 2-3x/wk ● 4-5x/wk ● Every Day ● Occasional ● 'Weekend Warrior'

Strength training exercise ● Never ● 1x/wk ● 2-3x/wk ● 4-5x/wk ● Every Day ● Occasional ● 'Weekend Warrior'

Tobacco ● Never ● Live(d) With Smoker ● Quit Smoking ● Cigarettes/Cigars/Chew ______ PER DAY

Alcohol ● Never ● Occasional ● ______ DRINKS PER WEEK **Coffee/Caffeine** ● Never ● Occasional ● ______ CUPS PER DAY

Water ______ GLASSES PER DAY **Fruits/Veggies** ______ PER DAY **Sugar Snacks** ● Never ● Occasional ● Daily

Hours of Sleep HOURS/NIGHT ______ **Do you feel rested when you wake up?** ● Yes ● No **Do you get daily quiet time?** ● No ● Yes

Have you had any major life changes in the past year? ______

Rate your stress level MARK 0 = **NONE** / 10 = **EXTREME** Occupational ______ Personal ______

How do you cope/manage your stress? ______

Rate your lifestyle MARK **POOR**, **GOOD**, OR **EXCELLENT** Diet ______ Sleep ______ General Health ______

Medications

PLEASE CHECK IF YOU ARE TAKING **ANY** OF THE FOLLOWING:

● Stimulants ● Antidepressants ● Blood Thinners ● Muscle Relaxers ● Birth Control

● Insulin ● Acid Reducers ● Blood Pressure ● Pain Killers NSAIDS, ASPRIN, IBUPROFEN

PLEASE LIST **PRESCRIPTION** AND **OVER-THE-COUNTER** MEDICATIONS YOU ARE CURRENTLY TAKING

MEDICATION ______ REASON ______ DOSAGE ______ DURATION ______

MEDICATION ______ REASON ______ DOSAGE ______ DURATION ______

MEDICATION ______ REASON ______ DOSAGE ______ DURATION ______

MEDICATION ______ REASON ______ DOSAGE ______ DURATION ______

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Supplements

PLEASE LIST **NUTRITIONAL SUPPLEMENTS** YOU ARE CURRENTLY TAKING

SUPPLEMENT ______ REASON ______ DOSAGE ______ DURATION ______

SUPPLEMENT ______ REASON ______ DOSAGE ______ DURATION ______

SUPPLEMENT ______ REASON ______ DOSAGE ______ DURATION ______

Prior Health History

Previous chiropractic care? ○ No ○ Yes

DOCTOR'S NAME ______ LAST VISIT ______ TYPE ______ **Did it help?** ○ No ○ Yes

Injuries

PLEASE LIST ALL INJURIES SUCH AS A **FRACTURES**, **FALLS**, **BROKEN BONES**, **HEAD INJURIES**, **LACERATIONS** ETC, AND OUTCOME

DATE ______ INJURY ______ OUTCOME ______

DATE ______ INJURY ______ OUTCOME ______

DATE ______ INJURY ______ OUTCOME ______

DATE ______ INJURY ______ OUTCOME ______

DATE ______ INJURY ______ OUTCOME ______

Motor Vehicle Accidents

LIST DATES, TYPE (**REAR END**, **FRONT**, **T-BONE,** OR **OTHER),** IMPACT (**HIGH**, **MEDIUM**, OR **LOW**), AND BRIEF DESCRIPTION OF SYMPTOMS/TREATMENT

DATE ______ TYPE ______ IIMPACT ______ SEATBELT? ______ SYMPTOMS/TREATMENT ______

DATE ______ TYPE ______ IIMPACT ______ SEATBELT? ______ SYMPTOMS/TREATMENT ______

DATE ______ TYPE ______ IIMPACT ______ SEATBELT? ______ SYMPTOMS/TREATMENT ______

DATE ______ TYPE ______ IIMPACT ______ SEATBELT? ______ SYMPTOMS/TREATMENT ______

Surgeries

PLEASE LIST DATES, PROCEDURE (**ESPECIALLY THOSE THAT REQUIRED GENERAL ANESTHESIA**), AND OUTCOME

DATE ______ PROCEDURE ______ OUTCOME ______

DATE ______ PROCEDURE ______ OUTCOME ______

DATE ______ PROCEDURE ______ OUTCOME ______

Allergies

PLEASE LIST ALL **ALLERGIES**, **REACTIONS**, AND **TREATMENT**

ALLERGY ______ REACTION ______ TREATMENT ______

ALLERGY ______ REACTION ______ TREATMENT ______

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Systems Review

PLEASE CHECK ALL THAT APPLY. **CIRCLE AREAS THAT ARE OF SERIOUS CONCERN OR MORE PROMINENT.**

Nervous System	WITHIN 6 MONTHS	PAST
Chills/Sweats		
Convulsions		
Dizziness		
Facial weakness		
Limb weakness		
Loss concentration		
Loss consciousness		
Loss of balance		
Loss of memory		
Numbness		
Ringing in ears		
Seizures		
Sleep disturbances		
Slurred speech		
Tremor		

Respiration	WITHIN 6 MONTHS	PAST
Asthma		
Bronchitis		
Chest pain/tightness		
Chronic cough		
Coughing up blood		
Phlegm production		
Shortness of breath		
Wheezing		

Ears	WITHIN 6 MONTHS	PAST
Discharge		
Hearing loss		
Infection		
Pain		

Cardiovascular	WITHIN 6 MONTHS	PAST
Angina		
Chest pain		
Heart murmur		
High blood pressure		
Low blood pressure		
Palpitations		
Poor circulation		
Prior heart attack		
Prior stroke		
Swelling in ankles		
Varicose veins		

Gastrointestinal	WITHIN 6 MONTHS	PAST
Abdominal pain		
Bloody stool		
Burping or gas		
Constipation		
Diarrhea		
Heartburn		
Hemorrhoids		
Hernias		
IBS		
Liver problems		
Nausea		
Ulcers		

Psychologic	WITHIN 6 MONTHS	PAST
Anxiety		
Bi-polar disorder		
Change of behavior		
Confusion		
Depression		
Insomnia		
Irritability		
Loss of appetite		
Memory loss		
Mood change		
Nervousness		

Eyes	WITHIN 6 MONTHS	PAST
Blind spots		
Blurred vision		
Double vision		
Dryness		
Pain		
Sensitivity		
Tearing		

General	WITHIN 6 MONTHS	PAST
Anemia		
Cancer		
Diabetes		
Drowsiness		
Epilepsy		
Fatigue		
Hypoglycemia		
Multiple Sclerosis		
TMJ		
Weight gain		
Weight loss		

Family History	YES	NO
Autoimmune disease		
Cancer		
Depression		
Diabetes		
Heart disease		
Multiple Schlerosis		
Osteoporosis		

Women Only	YES	NO
Are you pregnant?		
Infertility issues		
Irregular cycles		
Menopausal		
Nursing		
Painful menses		

Your Goals for Care

PEOPLE SEE CHIROPRACTORS FOR A VARIETY OF REASONS. SOME GO FOR RELIEF OF PAIN, SOME GO TO CORRECT THE CAUSE OF PAIN AND OTHERS GO FOR CORRECTION OF WHATEVER IS MALFUNCTIONING IN THEIR BODIES. WE WILL WEIGH YOUR NEEDS AND GOALS WHEN RECOMMENDING YOUR TREATMENT PLAN.

What aspects of your life would you like to have back? ______________________________

What are your expectations in receiving care with us? ______________________________

How would you like us to address your problem? ○ Symptomatic Relief Only ○ Corrective Care ○ Wellness Care

What phrase most accurately reflects your health goals? ○ Wellness ○ Prevention ○ Feel Good ○ Symptom Relief

How committed are you to correcting your problems? 0 = **NONE** to 10 = **FULLY** 0 1 2 3 4 5 6 7 8 9 10

How long do you think it will take to reach your health goals in the office? ______________________________

Acknowledgement

An evaluation will be performed which may include a spinal and physical examination, orthopaedic and neurological testing, palpation, specialized instrumentation, posture analysis and radiological examination.

We acknowledge that each patient is personally responsible for their own health through the choices they make and we make ourselves available to assist and help you with your health goals in any way we can. We want you to live a *life improved*.

By signing below, I acknowledge that the information I have provided is accurate and true.

Name ______________________________

Signature ______________________________ **Date** ____________________