Confidential Case History

We are pleased that you have chosen to consult us regarding your health. In order to help us evaluate your condition thoroughly, please complete the following form. This information is important so we ask that you be accurate. Please ask for assistance if needed.

Name: ____ Referred By: ____________________________

Address:___________________________________ City: ___________________ Postal Code:____________

- Where should we send correspondence by mail? ____

Home Phone: ___________________Work Phone: ______________________ Cell Phone: ________________

- Preferred Phone Number to leave messages: home work cell

e-mail: _________________________________ (we will be sending you information on your care to this address)

Birth date:_______________________________ Age: _________________ Sex: Male ___ Female ___

Occupation: ____________________________ Name of Business: ___________________________________

Type of Work:__ ___________________________ Hours Work/Study per week : ____________ _______________

Check One: ☐ Single ☐ Married ☐ Common Law ☐ Widowed ☐ Divorce ☐Separated ☐ Same Sex Relationship

Partner's Name: _______________________Names/ages of Children: ________________________________

I would like to receive Dr. Metz's personal health communiqué Yes No

May we send a thank you to the person who referred you to our office for care? Yes No

Your Health Profile

If you have no symptoms or complaints, and are here for wellness services, please check here _____, turn page over and complete. Those who have symptoms or complaints need to briefly describe the chief area of complaint, including the NEGATIVE IMPACT it has had on your QUALITY OF LIFE.

Reason For Attending Office:____

Location Of Problem?____

How Long Have You Had This Condition?____

Have You Had This (Or Similar) Conditions In The Past? _______________________________________

Pain Aggravated By? ____

Pain Relieved By? ____

Is Condition Getting Worse? ☐ Yes ☐ No ☐ Constant ☐ Comes And Goes

How is this negatively effecting:

Your Family Life? ___________________________ Your Career? ________________________________

Your Social Life? ___________________________ Your Physical Health & Recreation? ________________

Your Emotional Life? ________________________ Your Energy/Concentration? _____________________

Your Sleep Quality & Quantity? ________________

Have You Had Previous Chiropractic Care? ☐ **Yes** ☐ **No**

Where? _____________________________ **When?** ____

Why? _______________________________ **Were X-Rays Taken?** ☐ **Yes** ☐ **No**

Other Treatments Tried? ____

How Long Has It Been Since You Really Felt Good? ____

List any medications you are taking: ____

Other Health Problems?____

List Surgical Operations And Years:____

Pregnancies? ___________ Medical Doctor Name: ________________________ Phone: ________________

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to health potential.

When in your life did you experience any of the stresses listed below: C (child), T (teenager), A (adult), N (not at all)

I. PHYSICAL STRESS:

					Explain
Birth Trauma (your own birth)			Yes	No	
Slips/Falls	C	T	A	N	
Sports Injuries	C	T	A	N	
Poor Posture	C	T	A	N	
Extensive Computer Work	C	T	A	N	
Carrying Heavy Objects	C	T	A	N	
Repetitive Lifting/Bending	C	T	A	N	
Continuous Sitting/Standing (specify)	C	T	A	N	
Bone Fracture/Surgery (specify)	C	T	A	N	
Driving For Many Hours	C	T	A	N	
Car Accidents (How many? ____)	C	T	A	N	
Physical Abuse	C	T	A	N	
Work Injuries (How many? ____)	C	T	A	N	
Sleeping Position/Stomach	C	T	A	N	

II. CHEMICAL STRESS:

					Explain
Smoker – Amount? _____	C	T	A	N	
Second-Hand Smoke	C	T	A	N	
Poor Diet	C	T	A	N	
Alcohol (and how much)	C	T	A	N	
Caffeine (and how much)	C	T	A	N	
Excessive Sugar	C	T	A	N	
Artificial Sweeteners	C	T	A	N	
Prescription Drugs	C	T	A	N	
Over-The-Counter Drugs (Tylenol, Advil, etc.)	C	T	A	N	
Environmental Pollution (Air, Water, etc.)	C	T	A	N	

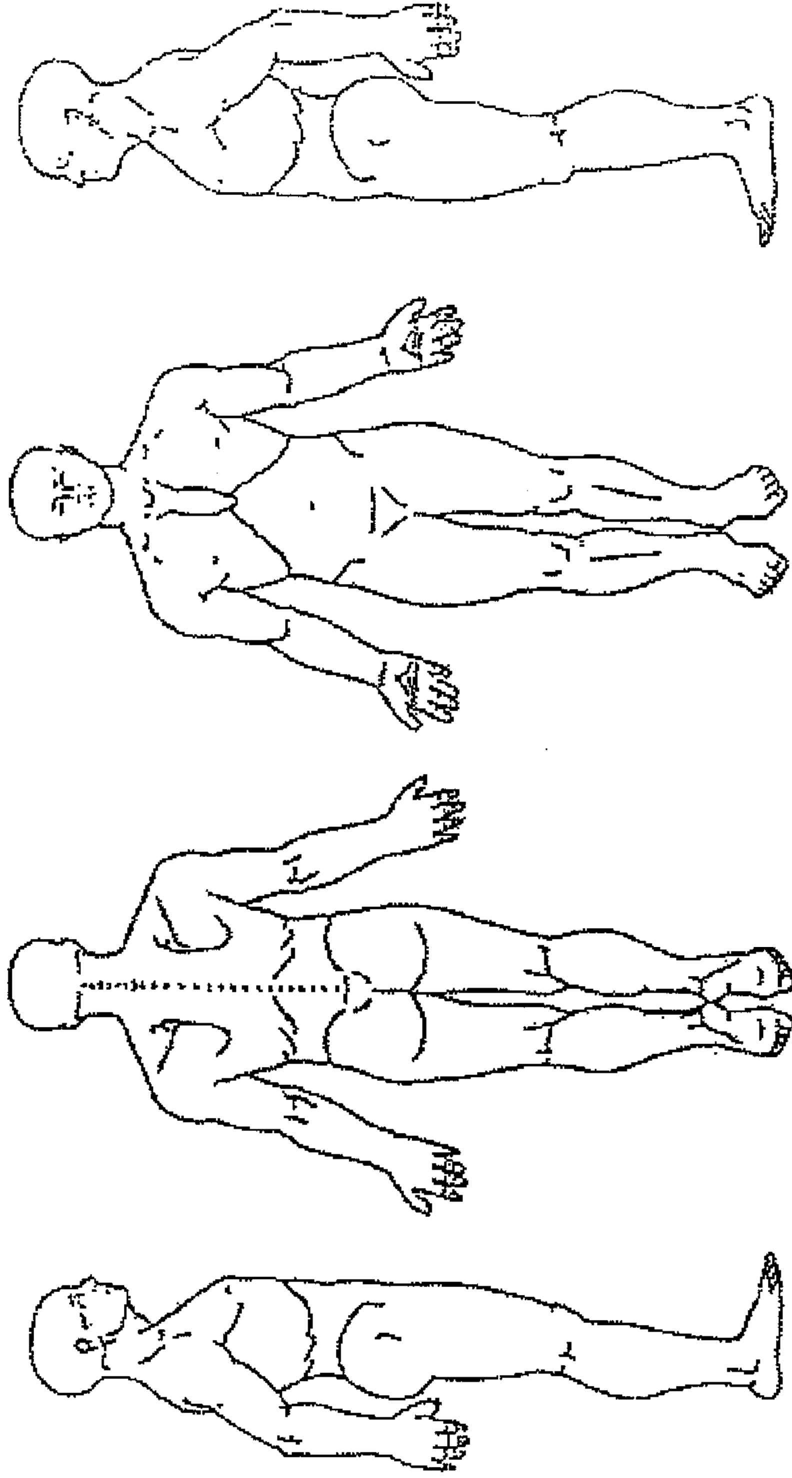
III. EMOTIONAL STRESS:

					Explain
Relationships	C	T	A	N	
Career	C	T	A	N	
Children	C	T	A	N	
Fast-Paced Life	C	T	A	N	
Internalized Feelings	C	T	A	N	
Perfectionist	C	T	A	N	
Procrastinator	C	T	A	N	
Sickness or Loss of a Loved One	C	T	A	N	
Quick Temper	C	T	A	N	
Verbal Abuse	C	T	A	N	

IV. **WHICH DO YOU FEEL IS YOUR PRIMARY STRESS?** ☐ PHYSICAL ☐ CHEMICAL OR ☐ EMOTIONAL?

Explain: ____

Please FILL IN areas of PAST INJURY, SCARS and current dysfunction or discomfort:



Patient Name: ____________ DOB: ____________ Age: ________ Date: ____________

*skin roll, scratch test, drag, trophism, hollowed-out, HT, weakness, swelling * abnormal motion (active/passive) * joint restriction*

HISTORY

Scars – Past Injuries – Breaks – Sprains – Weakness – Pain - Dysfunction

Dr. Rosanne Metz – Park Road Healing Arts

28 Park Road – Toronto – Ontario – M4W 1M1 – 416-920-7275

Please check all symptoms you have had in the last year:

- ☐ Headaches
- ☐ Pins & Needles in Arms
- ☐ Dizziness
- ☐ Numbness in Toes/Feet
- ☐ Fatigue
- ☐ Sleeping Problems
- ☐ Diarrhea
- ☐ Cold Sweats
- ☐ Mood Swings
- ☐ Blurred Vision
- ☐ Pins & Needles in Legs
- ☐ Loss of Smell
- ☐ Buzzing/Ringing in Ears
- ☐ Numbness in Fingers/Hands
- ☐ Depression
- ☐ Stiff Neck
- ☐ Constipation
- ☐ Sensitive Eyes
- ☐ Menstrual Pain
- ☐ High Blood Pressure
- ☐ Fainting
- ☐ Back Pain
- ☐ Loss of Concentration
- ☐ Loss of Taste
- ☐ Irritability
- ☐ Cold Hands
- ☐ Fever
- ☐ Problem Urinating
- ☐ Menstrual Irregularity
- ☐ Asthma
- ☐ Neck Pain
- ☐ Loss of Balance
- ☐ Nervousness
- ☐ Upset Stomach
- ☐ Tension
- ☐ Cold Feet
- ☐ Hot Flashes
- ☐ Heartburn
- ☐ Ulcers
- ☐ Sinusitis

Anything Else You Feel We Should Know About: ____

____

____

Imagine you could wave a magic wand and wish for 10 things to change about your health in the year to come.

Things I would like to HAVE in my life:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Things I would be happy WITHOUT in my life:

6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Many health problems are the result of hereditary spinal weaknesses, thus, information about your family members will give us a better picture of your total health. Please mention below any health conditions or concerns you may have about your:

Children: ____

Spouse: ____

Mother: ____

Father: ____

Brother(s): ____

Sister(s): ____

Others: ____

People go to Chiropractors for a variety of reasons. Some seek care for relief of pain and discomfort only. Others wish to address the underlying cause of the problem, to increase their health potential and prevent the problem from returning. Please check which type of care you are seeking:

☐ Relief Care ☐ Wellness

If you checked off relief care, please let us know why you are not interested in feeling well all of the time.

____

Please fill in where you are "Now" and where your "goal" is on a scale of one to ten in the following areas of your life:

.

1/10 *is very low/poor/stressful* ***10/10*** *is very high/happy/stressfree*

Please feel free to add comments where you like.

AREA OF LIFE AFFECTED	Now	Goal	Comments
Your Family Life	/10	/10	
Your Friendships & Social Life	/10	/10	
Your Career	/10	/10	
Your Physical Health & Recreation	/10	/10	
Your Nutrition & Chemistry (think food, drugs, other toxins)	/10	/10	
Your Emotional Life	/10	/10	
Your Energy Level	/10	/10	
Concentration	/10	/10	
Your Sleep Quality & Quantity	/10	/10	
Other	/10	/10	

Present State of Health /10

Short Term Goals /10

Long Term Goals /10

1. ____
2. ____
3. ____