HEALTH HISTORY FORM

Today's Date: _____ How did you hear about our office? _____

First Name: _____ Last Name : _____ Preferred First Name:_____

Street Address: _____ City: _____ Province: _____ Postal Code: _____

Best Phone Number to be Reached at :_____ Age: _____ Birthdate: (M)_____/(D)_____/(Y)_____

Marital Status:_____ Spouse Name:_____

Number of Children:_____ their names and ages:_____

Occupation:_____ Employer: _____

Patient ID #

THE PURPOSE OF MY VISIT

- ❑ Symptom relief and preventing its return.
- ❑ 100% optimum health and wellbeing on every level available to me.
- ❑ My commitment level to optimal health is (please rate from 0 to 10) : 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

CHIROPRACTIC HISTORY

Have you been to a chiropractor before? Yes/No Name of previous chiropractor: _____

How long were you under care? _____ What were the results?_____

ICBC – CAR ACCIDENTS

Have you been in a car accident in the last 12 months? Yes/No If yes: Accident Date: _____

Do you have an open claim with ICBC for this accident? Yes/No If yes, ICBC Claim #: _____

Have you seen a chiropractor for this claim? Yes/No If yes, chiropractor's name_____

YOUR MEDICAL HISTORY

Please check any of the following conditions currently or recently experienced:

- ❑ Head Pain
- ❑ Headaches
- ❑ Migraines
- ❑ Sinus Problems
- ❑ Ringing in Ears
- ❑ Jaw Problems
- ❑ Neck Pain
- ❑ Shoulder Pain: Left / Right
- ❑ Arm Pain: Left / Right
- ❑ Hand/Wrist Pain: Left / Right
- ❑ Carpal Tunnel Syndrome: Left Right
- ❑ Chest Pain
- ❑ Upper Back Pain
- ❑ Mid Back Pain
- ❑ Low Back Pain
- ❑ Rib Pain: Left / Right
- ❑ Hip Pain: Left / Right
- ❑ Disc Herniation
- ❑ Sciatica: Left / Right
- ❑ Knee Pain: Left / Right
- ❑ Ankle Pain: Left / Right
- ❑ Menstrual Pain / Irregularity
- ❑ Prostate Problems
- ❑ Dizziness/Vertigo
- ❑ Hearing / Ear Problems: Left / Right
- ❑ Asthma
- ❑ Difficulty Breathing
- ❑ Thyroid Problems: Underactive/Overactive
- ❑ Acid Reflux
- ❑ Heartburn
- ❑ Ulcers
- ❑ Stomach / Digestive Problems
- ❑ Constipation:_____
- ❑ Diarrhea
- ❑ Liver Problems
- ❑ Gallbladder Problems
- ❑ Kidney Problems
- ❑ Immune Function Problems
- ❑ Chronic Fatigue/Fibromyalgia
- ❑ Skin Problems
- ❑ Allergies:_____
- ❑ Gout
- ❑ Arthritis
- ❑ Fertility Problems
- ❑ Sexual Functioning Problems
- ❑ Low Energy
- ❑ Sleeping Problems
- ❑ Anxiety
- ❑ Depression
- ❑ Hot Flashes
- ❑ Weight Problems
- ❑ Alcohol / Substance Challenges
- ❑ Blood Pressure Problems: Low/High
- ❑ High Cholesterol
- ❑ Heart Problems:_____
- ❑ Stroke
- ❑ Diabetes: Type 1 / Type 2
- ❑ Aids/ HIV
- ❑ Multiple Sclerosis
- ❑ Cancer:_____
- ❑ Recurrent Infections:

___ Ear
__ Sore Throat
__ Respiratory/Colds
__ Bladder Infections
__ Yeast Infections

- ❑ Family History: diabetes / cancer / heart disease / other family related illness
- ❑ Other conditions:_____

Patient ID #

MAJOR HEALTH CONCERNS

Please identify 3 major health concerns you are currently experiencing.
On a scale of **0** to **10,** with **zero** being no pain and **10** being the worst pain, rate your concerns by ***circling the number*** **:**

Problem # 1_____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the problem begin? _____ How did the problem begin? _____
Is it: ❑ Getting better ❑ Getting worse ❑ Staying the same
Pains are: ❑ Dull ❑Ache ❑ Tightness ❑ Throbbing ❑ Spasm ❑ Numb ❑ Sharp ❑ Burning ❑ Shooting
How long does it last? ❑ Its constant ❑ I experience it on and off during the day ❑ It comes and goes through the week
What activities aggravate this problem? Please describe: _____
Is there anything that relieves your symptoms? ❑ No ❑ If yes, please describe: _____

Problem # 2_____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the problem begin? _____ How did the problem begin? _____
Is it: ❑ Getting better ❑ Getting worse ❑ Staying the same
Pains are: ❑ Sharp ❑ Dull ❑Ache ❑ Burning ❑ Tightness ❑ Throbbing ❑ Spasm ❑ Numb ❑ Shooting
How long does it last? ❑ Its constant ❑ I experience it on and off during the day ❑ It comes and goes through the week
What activities aggravate this problem? Please describe: _____
Is there anything that relieves your symptoms? ❑ No ❑ If yes, please describe: _____

Problem # 3_____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
When did the problem begin? _____ How did the problem begin? _____
Is it: ❑ Getting better ❑ Getting worse ❑ Staying the same
Pains are: ❑ Sharp ❑ Dull ❑Ache ❑ Burning ❑ Tightness ❑ Throbbing ❑ Spasm ❑ Numb ❑ Shooting
How long does it last? ❑ Its constant ❑ I experience it on and off during the day ❑ It comes and goes through the week
What activities aggravate this problem? Please describe: _____
Is there anything that relieves your symptoms? ❑ No ❑ If yes, please describe: _____

MEDICATIONS
List all medications you are taking (prescription & over the counter) : _____

_____

SURGERIES
List all surgeries you have had in your life : _____

BROKEN BONES
List all broken bones you have had in your life : _____

OPT-IN CONSENT FOR EMAIL

- I agree to receive emails from Coquitlam Family Chiropractic for my appointments, statements, x-rays. office closures and special events.
- The email I would like to have on file is a personal, non-shared, confidential email. I assure Coquitlam Family Chiropractic that information sent to this email is secure and does not place Coquitlam Family Chiropractic at risk of breaching confidentiality or privacy regulations.
- The Statements made on this form are true to the best of my knowledge and I consent to allow Coquitlam Family Chiropractic to further evaluate my condition with an exam and other tests as deemed necessary by the doctors.

E-mail: _____ **Signature:** _____