

Family Health Centre

33 Lewis Street
Perth ON K7H 2R4
T. 613 267 2951
800 267 2879
F. 613 267 7015
info@perthfamilyhealth.com
www.perthfamilyhealth.com

PERSONAL INFORMATION

DATE _____

Perth Chiropractic

Dr. Warren S. Hollis B.Sc., D.C., CPed(C)
Chiropractor, Pedorthist

Dr. Elaine Chagnon B.Sc. (Nursing), D.C.
Chiropractor and ART® provider

Dr. Jennifer Fergusson B.A.Sc., D.C.
Chiropractor

Client Name: _____

Birth Date: _____ Age: _____

DD / MM / YY

Mailing Address: _____

P.O. Code: _____ Home Phone #: _____

Work Phone #: _____

E-mail: _____

May we send information related to your health care to your e-mail address? Y N

Place of Employment: _____

Occupation: _____

Present Medical Doctor: _____

We routinely inform family physicians of your care - do you wish for us to communicate with your M.D.? Y N

If today's appointment is regarding a work-related injury or a car accident, please indicate:

Work Car Date of accident _____

How did you hear of our office?

Family member or friend
(their name _____)

Referred from M.D., Massage Therapist, etc.
(their name _____)

We do send updates to referring professionals

Yellow Pages

Sign

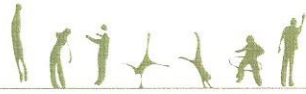
Other

Have you had previous chiropractic care? Yes No

Approximate date of last visit: _____

DD / MM / YY

"Helping People Lead Better and Easier Lives"



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Name: _____
 Date: _____
 File #: _____

HEALTH HISTORY

Please check off the circle beside the condition(s) that apply to you currently.

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia / Bleeding disorders | <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Psychological Problems |
| <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Nose/ throat problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Concussions | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Constipation | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> HIV / Aids | <input type="checkbox"/> Colitis | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Crohn's | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Depression | <input type="checkbox"/> Previous vehicle accidents |
| <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Previous Surgeries |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Recent weight changes |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Frequent Colds / Flu | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Seizures / Epilepsy | <input type="checkbox"/> Headaches/ Migraines | <input type="checkbox"/> Sinus/Drainage Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Transmittable Diseases | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Acid Reflux/ Heartburn | <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Swallowing problems |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Irritable Bowel Syndrome (IBS) | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Impotence / Sexual Dysfunction | <input type="checkbox"/> TMJ/ Dental Appliances |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Kidney/Bladder/ Bowel Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma/ Bronchitis | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Tumor / Malignancy |
| <input type="checkbox"/> Arthritis/ Joint Pain | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Vertigo / Dizziness |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Menstrual Dysfunction | <input type="checkbox"/> Vision / hearing problems |
| <input type="checkbox"/> Celiac | <input type="checkbox"/> Mood Disorders | |

Other: _____

What is your goal of coming here today? _____

Have you ever had a serious illness or health emergency? No Yes (List all condition(s) including the year): _____

Have you ever had an operation/surgery? No Yes (List all surgery(s) including the year): _____

Do you have any genetic disorders or disabilities? No Yes (Explain): _____

Have you ever had a fall or accident? No Yes (Explain) _____

Have you ever been unconscious? No Yes (Explain): _____

Do you wear orthotics or foot supports? No Yes How old are they? _____

Continued on next page →

LIFESTYLE HABITS

How often do you smoke? Never In the Past Occasionally Daily Other: _____

How often do you drink alcohol? Never In the Past Occasionally Daily Other: _____

Do you drink coffee? No Yes How many cups per day? _____

Rate your diet: Poor Fair Medium Good Excellent

Rate your appetite: Poor Fair Medium Good Excellent

How many glasses of water do you drink per day? _____

How many meals do you eat per day? _____

How often do you exercise? Never In the Past Occasionally Daily Other: _____

What is your typical work activity? (Check all that apply): Light Lifting Heavy Lifting Physical Repetition
 Excessive Sitting Excessive Standing Low Stress High Stress Other: _____

Are you currently taking any over-the-counter or prescription drug, vitamin/supplement or natural remedy?
 No Yes (Please list the name & reason for taking): _____

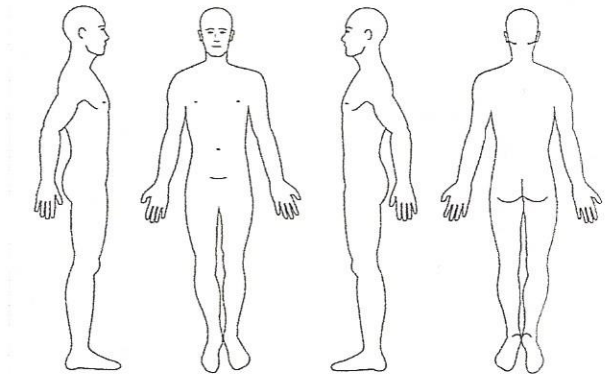
CURRENT SYMPTOMS

Select which is true for you:

I **DO NOT** have symptoms. I am seeking chiropractic care to maintain wellness.

I **DO** have symptoms. (List all of your symptoms on the lines below)

In this diagram to the right, mark the figures in relation to where you experience your symptoms on your body.



HEALTH GOALS: Select all of your current health and lifestyle goals.

- Relieve Pain/Discomfort
- Relieve Muscle Tension
- Reduce Medication
- Restore Proper Function
- Improve Diet/Nutrition
- Increase Energy
- Improve Posture
- Improve Work/Life Balance
- Improve Self Confidence
- Improve Mobility
- Improve Flexibility
- Increase Self Confidence
- Restore Emotional health
- Arthritis Management
- Drink More Water
- Treat Illness
- Strengthen Immune System
- Improve Sleep Habits
- Decrease Anxiety
- Quit Unhealthy Habit
- Maintain healthy Body Weight
- Reduce Heart Disease Risk Factors
- Improve Athletic Performance

STRESS ASSESSMENT

Select all of the emotional, physical, and chemical stress you have experienced in the past 3 months:

- Slip/Falls
- Poor Diet/ Nutrition
- Lack of Sleep
- Occupational Stress
- Car Accident
- Excessive Sitting
- Death of a Loved One
- Financial Stress
- Sports Injury
- Excessive Standing
- Hospitalization
- Surgery/ Operation
- Depression
- Lack of Exercise
- Increase of Exercise
- Change in Medication

Patient/Guardian Name & Signature

Witness Signature

Date