Parkwood Chiropractic Centre

166 Manitoba Street, Bracebridge / Ontario / P1L 2E2 / (705) 646-8887

CONFIDENTIAL PATIENT HISTORY

Dear Patient:
Please complete these forms as carefully as possible, as each question gives us a clearer picture of your current health. Our goal is to address the issues that brought you to this office and in order to give you the best possible Chiropractic care; we will need to assess the stresses that are placed on your body.

Date: _____

Name:	Date of birth (Day/Month/Year):	Age:
Home Address with Postal Code:	Employer:	
Home Phone Number:	Work Phone Number:	
Cell Phone:	e-mail address:	
Family Medical Doctor:	Referred by (please include person's name): □ Friend □ M.D. / D.C. □ Internet / Add □ Other	
Would you like to have a Report of Findings sent to your MD? (Please circle) Yes No	If yes, please sign:	
Have you had Chiropractic care before? If so, when and by whom?	Children's Name and Ages:	
Please circle gender: Male Female	Please circle marital Status: M S W D Spouse's Name:	

Please describe your current problem, including the effect it has had on your life:

_____

_____

_____

_____

Please describe the character of your pain (check all that apply)

□ Sharp/Stabbing □ Sharp/Dull □ Achy □ Dull
□ Throbbing/Gnawing □ Numbness □ Shooting □ Weakness
□ Burning □ Tingling □ Gripping/Constricting □ Soreness
□ Other: _____

How often are the complaints present?

□ Constant (76-100%) □ Frequent (51-75%) □ Occasional (26-50%) □ Intermittent (25% or less)

When is the pain or symptoms worse:

□ When you wake up □ During the day □ After work □ In the evening □ After eating
□ While sleeping □ Getting up from sitting □ While walking

PLEASE TURN OVER →

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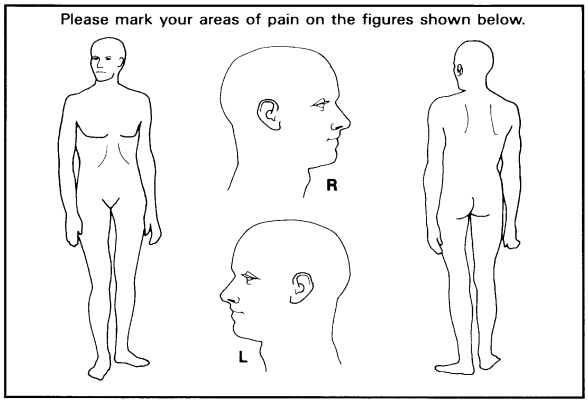
When did your problem begin: _____ (specific date if possible)

Since your problem began is the pain: □ increasing □ decreasing □ not changing

How bad is your pain or ache? Please circle a number (0=no pain, 10=unbearable pain)

0	1	2	3	4	5	6	7	8	9	10

Please draw on the diagram where you feel your symptoms:



Who else have you seen for this condition: _____

_____

Please list any **falls**, **auto accidents** or **major injuries** (include Month/Year, Type of accident):

_____

_____

_____

Please list any and all past surgeries: _____

_____

Have you had **x-Rays** in the past 4 years? _____ Date: _____ Area x-rayed _____
Where? _____

Please list ANY and ALL medication (prescription and over the counter): that you are currently taking:

_____

_____

Do you take any of the following:
□ Pain Killers □ Muscle Relaxants □ Cholesterol lowering drugs □ Anti Inflammatory □ Anti-Depressants
□ Recreational Drugs (discuss with Doctor) □ Other (please list)

Have you **personally** had the following: (please check all that apply)
□ Aneurism □ Osteoporosis □ Diabetes □ Thyroid Disease □ Arthritis □ Stroke
□ Heart Condition □ High Blood Pressure □ Asthma □ Polio □ Psoriasis
□ Cancer type:_____ When diagnosed:_____ Has it spread Y N
□ Other: _____

Are the following in your **family history:** (please check all that apply)
□ Aneurism □ Osteoporosis □ Diabetes □ Thyroid Disease □ Arthritis □ Stroke
□ Heart Condition □ High Blood Pressure □ Asthma □ Polio □ Psoriasis
□ Cancer type:_____
□ Other: _____

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Your name: _____

Please check all symptoms or areas where you have problems, even if they do not seem related to your current problem.

□ Headaches/Migraines	□ Buzzing/Ringing in Ears	□ Lungs	□ Low Back Pain
□ Dizziness	□ Fatigue	□ Heart	□ Hip Pain
□ Eyes/Vision	□ Fainting	□ Stomach	□ Leg Pain/Cramps
□ Concentration Loss	□ Sinus	□ Indigestion	□ Poor Circulation
□ Depression	□ Neck Pain/Stiffness	□ Bladder	□ Numb Feeling
□ Nervousness	□ Shoulder	□ Liver	□ Feeling of Pins/Needles
□ Sleeping	□ Upper Back	□ Colon	□ Hot Flashes
□ Loss Energy	□ Mid Back	□ Kidney	□ Cold Sweats
□ Tired Mornings	□ Chest Pain	□ Constipation	□ Diarrhea
□ Loss of Taste/Smell	□ Menstrual Pain/Irregularity	□ Urination	□ Fever
□ Breathing	□ PMS	□ Colic	□ Chronic Ear Infections

Do you currently smoke? Yes No. If YES please indicate how many packs a day _____
Number of years _____

Physical activity at work:
□ Sitting more than 50% □ Light manual labour □ Heavy manual labour

General physical activity:
□ No regular exercise program □ Light exercise program □ Strenuous exercise program

How would you rate your stress level on a scale from 1-10 (10 being the worst)
Family Stress Occupational Stress Other stresses (please note)

How would you rate your health:

I've never felt worse — I feel great

1 2 3 4 5 6 7 8 9 10

How committed are you to improving your health:

Not important — I want to be 100% healthy

1 2 3 4 5 6 7 8 9 10

What does being healthy mean to you (check all that apply)?

□ Not being sick
□ Being symptom free
□ Having energy to do what I want, when I want
□ Not needing to take time off work
□ To fully enjoy all aspects of life to the fullest extent possible.

What is your goal or expectations with Chiropractic care: _____

_____

_____

_____

Why Chiropractic? People go to chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective care). Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

□ Relief Care □ Corrective Care □ Supportive Care □ I want the doctor to select care needed

Patient's Signature: _____ Date: _____
(Signature Authorizing Care)