

Live Well

Family Health Centre

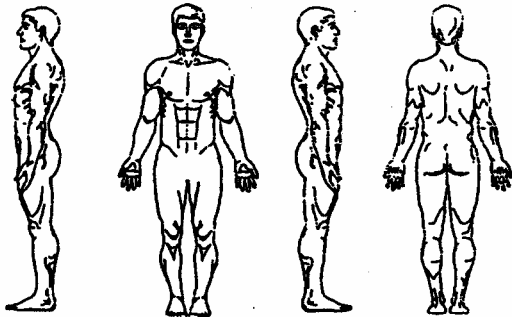
Chiropractic • Massage • Yoga • Nutrition
Natural Pharmacy • Orthotics • Naturopathy

HEALTH HISTORY

Name: _____ Today's Date (D/M/Y): _____
 Name you preferred to be called: _____ Date of Birth (D/M/Y): _____ Age _____
 Address: _____ City: _____ Postal Code: _____
 Phone: Home _____ Work: _____ Occupation: _____
 E-mail: _____ May we contact you by email: Yes No
 Marital Status: Single Married Widowed Divorced Other Children: No Yes #__
 Who referred you? /How did you hear about us?: _____

1) Have you seen a chiropractor before? Yes No
 If yes, Chiropractor's name: _____ Last Visit: _____
 X-rays taken: Yes No When: _____

2) What brings you to the office? Wellness _____ Physical Complaint_ _____
 If it is a physical complaint please shade in the areas below:



What symptoms are you experiencing?

- | | |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Dull ache | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Twitching | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Fiery | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Radiating | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness |
- 3) How

would you rate the severity of your complaint? Please mark a vertical line on the scale below.

NO PAIN ————— WORST PAIN

4) How would you rate your overall health? Please mark a vertical line on the scale below.

VERY SICK ————— VERY HEALTHY

5) Are you currently taking any medications? Yes No

If yes, please list: _____

6) Are you currently taking any supplements? Yes No

If yes, please list: _____

7) Please finish the following sentences by circling a number from 1 to 10.
(1 – poor, 5 – average, 10 – excellent)

My STRESS LEVEL is:	1	2	3	4	5	6	7	8	9	10
My ENERGY LEVEL is:	1	2	3	4	5	6	7	8	9	10
My BREATHING is:	1	2	3	4	5	6	7	8	9	10
My LEVEL OF RELAXATION is:	1	2	3	4	5	6	7	8	9	10
My QUALITY OF SLEEP is:	1	2	3	4	5	6	7	8	9	10
My DIGESTION is:	1	2	3	4	5	6	7	8	9	10
My MEMORY is:	1	2	3	4	5	6	7	8	9	10
My RESISTANCE TO ILLNESS is:	1	2	3	4	5	6	7	8	9	10
My FLEXIBILITY is:	1	2	3	4	5	6	7	8	9	10
My CONCENTRATION is:	1	2	3	4	5	6	7	8	9	10

8) List any operations, motor vehicle accidents and/or hospitalizations and the year they occurred: _____

9) Please check the conditions you are experiencing now or have in the past:

- | | | | |
|------------------------------------|--|--|---|
| General | Respiratory | Cardiovascular | Digestion |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Hiatus hernia |
| <input type="checkbox"/> Rash | <input type="checkbox"/> Short breath | <input type="checkbox"/> Stroke/ TIA | <input type="checkbox"/> Crohns/Colitis |
| Other Conditions | | | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Depression |

Use this space to elaborate on any of the above conditions or any conditions that have not been listed:

10) Please list a brief family health history: _____

11) List any activities that you do to promote good health: _____

12) What health goals would you like to achieve through chiropractic: _____
