WELLINGTON CHIROPRACTIC AND WELLNESS GROUP
CONFIDENTIAL PATIENT HEALTH HISTORY

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Name: _____ Birth Date: D_____M____YR_____ Age: _____ Sex: M □ F □

Address: _____City:_____ Postal Code: _____

Marital Status: Married Single Common Law Number of Children: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____ Ext: _____

E-mail:_____ Employer:_____Type of Work: _____

Preferred method of contact: □Home phone □Cell phone □Work phone □E-mail

Medical Doctor's Name and Phone Number: _____

Have you had previous Chiropractic Care? □ None □ DC's Name and last visit:_____

Do you have extended health care insurance (Benefits, Group Insurance)? □ No □ Yes Amt. $ _____

Who may we thank for referring you to our office? _____

CURRENT HEALTH PROFILE

As a full service wellness office, our focus is on your ability to achieve optimal health. Our goals are to address the issues that brought you to this office, as well as offering you the opportunity to explore 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.

If you have no symptoms or complaints presently, and are here for wellness services, (√) check here _____ and skip to Past Health Profile. Those with symptoms or complaints need to briefly describe the chief area of complaint.

What is the purpose of this appointment? _____

Other practitioners seen for this condition? □ No □ Yes Who and When? _____

List any therapy or diagnostics done to date: _____

When did this condition begin? _____ Has it occurred before? □ No □ Yes When? _____

Is the condition: □ Job Related □ Auto Accident □ Home Injury □ Fall □ Other _____

Date of Accident: _____ (supplemental forms required for motor vehicle and work accidents)

What aggravates your condition? _____ What relieves your condition? _____

Is your condition: □ Becoming Worse □ Constant □ Comes and Goes □ Improving

Character of Pain: □ Sharp □ Dull □ Ache □ Pins & Needles □ Numb □ Burning □ Travels to_____

Does your condition interfere with: □ Work □ Sleep □ Hobbies/Sports □ Happiness/Quality of life

Do you currently take any medications or supplements? Please List: _____

_____

Have you had Spinal X-Rays taken in the last 12 months? □ No □ Yes Where? _____

PAST HEALTH PROFILE

Below is a list of symptoms or illnesses which may seem unrelated to the purpose of your appointment, however, these questions must be answered carefully, as these conditions may affect your overall course of chiropractic care. Check any of the following **you experience currently, or have had in the recent (6 months) past:**

□ neck pain	□ forgetfulness	□ shortness of breath	□ excessive thirst
□ chewing/jaw problems	□ stress	□ blood pressure problems	□ painful/excessive urine
□ hearing loss	□ walking problems	□ irregular heart beat	□ poor/excessive appetite
□ stuffed nose	□ nervousness	□ heart problems	□ frequent nausea
□ dental problems	□ numbness	□ lung congestion	□ vomiting
□ arm pain	□ paralysis	□ varicose veins	□ diarrhea
□ fatigue	□ tingling extremities	□ ankle swelling/edema	□ constipation
□ loss of sleep	□ joint pain/stiffness	□ stroke	□ liver problems
□ allergies	□ fever	□ bladder trouble	□ gall bladder problems
□ headaches	□ sore throat	□ sexual dysfunction	□ weight trouble
□ vision problems	□ ear aches/infections	□ menstrual irregularity	□ abdominal cramps
□ convulsions/seizures	□ recurrent colds/flus	□ vaginal pain/infection	□ heartburn
□ dizziness	□ pain between shoulders	□ breast pain/lumps	□ black/bloody stool
□ depression	□ low back pain	□ prostate dysfunction	□ colitis
□ fainting	□ chest pain	□ discoloured urine	

FEMALES ONLY:

When was your last period? _____
Are you pregnant? □ Yes □ No □ Unsure

STRESS INDEX

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 your health potential. Research is showing that many of the health challenges that occur in later life have their origins during the developmental years, some starting at birth. Please answer to the best of your ability:

Were you vaccinated as a child?	□ Yes □ No	_____
Any significant falls in childhood?	□ Yes □ No	_____
Any childhood hobby or sports injuries?	□ Yes □ No	_____
Any significant childhood illnesses?	□ Yes □ No	_____
Were you ever hospitalized as a child?	□ Yes □ No	_____
Any mental or physical abuse as a child?	□ Yes □ No	_____
Were you ever involved in a motor vehicle accident?	□ Yes □ No	_____
Any notable falls or injuries as an adult?	□ Yes □ No	_____
Any hobby or sports injuries as an adult?	□ Yes □ No	_____
Do you exercise regularly?	□ Yes □ No	_____
□ Daily □ Weekends □ Infrequently		
Do you maintain proper posture?	□ Yes □ No	_____
Have you been assessed/fitted for orthotics?	□ Yes □ No	_____
Are you/have you ever been over your ideal weight?	□ Yes □ No	_____

Sleep posture- □ Side □ Back □ Stomach

Do you eat as healthy as you think you should? □ Yes □ No _____
Do you smoke? Amount _____ □ Yes □ No _____
Do you drink alcohol? □ Yes □ No _____
□ Daily □ Weekends □ Infrequently
Do you/have you taken narcotics? □ Yes □ No _____
Do you have work stress? (Rate 1-10, 1=none, 10=extreme) □ Yes □ No _____
Do you have personal stress? (Rate 1-10, 1=none, 10=extreme) □ Yes □ No _____

FAMILY HEALTH PROFILE

As a family oriented wellness centre, we are not only interested in your health and well-being, but also the health and well-being of your loved ones. Please mention below any health condition or concerns you have about your:

	Names and Ages	Condition(s)
Children	_____	_____
Spouse/Partner	_____	_____
Sister(s)	_____	_____
Brother(s)	_____	_____
Mother	_____	_____
Father	_____	_____
Other	_____	_____

ABOUT YOUR CARE

Chiropractic provides three types of care. The first is Initial Intensive Care, which corrects the most recent layer of spinal and neurological damage. This care usually reduces or eliminates symptoms. Then begins Reconstructive/Corrective Care, which corrects the years of damage that occurred when there were few symptoms. Finally, Chiropractic offers a genuine approach to wellness care. Based on these definitions, I have primarily consulted this office because:

□ I am interested in reaching my optimal health potential (Wellness care).

□ I have a health concern, and I want the cause of this corrected and symptoms relieved (Corrective care).

□ I am only interested in the relief of pain (Relief care).