New Hamburg Wellness Centre
PATIENT HEALTH HISTORY

Dear Patient,

Our primary purpose for collecting personal information about you is to provide you with health services. Information about your health history, your physical condition, function, and your social situation are collected in order to help the doctor assess what your needs are, to advise you of your options, and then to provide the health care you choose to have.

Our ability to draw effective conclusions about your present state of health and how to improve it, depends to a significant extent on your ability to respond thoughtfully and accurately to both these written questionnaires and those questions posed by the doctor during your consultations. There may be questions that may not be relevant/pertaining to your condition. Simply leave these blank for the time being and proceed from there. Thank you for your time in advance and we look forward to working together to achieve your health goals.

NAME: ____________________ **TODAY'S DATE:** ____________

DATE OF BIRTH: M______**D**______**Y**______ **SEX: M F HEIGHT:** ______ **WEIGHT:** ______

ADDRESS: ____

________________________________ **POSTAL CODE:** ____________

PHONE NUMBER: (HOME)____________ **(WORK)**____________ **EXT.** ______

(CELL) ____________ **EMAIL ADDRESS:** ____________________

OCCUPATION: ____________________ **EMPLOYER:** ____________________

HEALTH CARD #: ____________ **VERSION CODE:** ______ **EXPIRY:** ______

MEDICAL DOCTOR: ________________________________

PAST CHIROPRACTOR & LAST VISIT: ________________________

HOW DID YOU HEAR ABOUT OUR CLINIC?: ____________________

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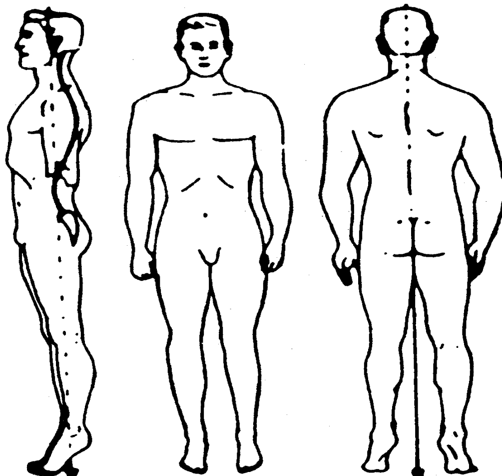
1. **What is your primary reason for seeking care at our centre?** ____________________

____

____

On the diagrams below please indicate the area(s) of your chief complaint(s) using the symbols provided



Numbness	= = =
Pins & needles	# # #
Burning	x x x
Sharp & stabbing	/ / / /
Dull & aching	+ + +
Stiff & tight	2 2 2

2. **Are there any secondary reasons for seeking care at our centre?** ____________________

____

____

3. **Was there an injury, trauma, health significant event which may have contributed? ___________________**

   ____

4. **How long have you had this condition or these health concerns? ___________________________________**

5. **Any similar or potentially related occurrences/episodes in the past? Y N When? ________________**

   Please explain and include treatment/interventions you found to be helpful: _________________________

   ____

6. **Please indicate below the severity of any discomfort or any pain you feel now:**

		(0)		(10)
Symptom:	______________________________	**Minimal**	·__·__·__·__·__·__·__·__·__·__	**Extreme**
Symptom:	______________________________	**Minimal**	·__·__·__·__·__·__·__·__·__·__	**Extreme**
Symptom:	______________________________	**Minimal**	·__·__·__·__·__·__·__·__·__·__	**Extreme**
Symptom:	______________________________	**Minimal**	·__·__·__·__·__·__·__·__·__·__	**Extreme**

7. **Is your area of primary concern and/or general health:**

   getting better _______ staying the same _______ getting worse ______. Why do you think so?

   ____

8. **What activities, factors or positions aggravate your signs and symptoms? ___________________________**

   ____

9. **What if anything have you found to relieve or improve your signs and symptoms? ___________________**

   ____

10. **Please list all surgical operations you have had, the approximate dates, why you had them and the net result: ____**

    ____

    ____

11. **Please share any significant stressors that could still be impacting your well-being (e.g. change of job, relationship conflict, work environment, loss of loved one, history of abuse, accidents/traumas, addictions, etc.): ____**

    ____

12. **Please indicate the main goal(s) of the treatment/care you would like to receive.**
    Please check all that apply:

☐ Pain Relief
☐ Home Exercise Program
☐ Prevention of Re-occurrences
☐ Regular Maintenance Care
☐ Rehabilitation and Strengthening
☐ Second Opinion
☐ Other: ____

____

Check the following conditions you have had/or have:

___AIDS ___Cancer ___Eczema/Psoriasis ___Poliomyelitis
___Allergies ___Colitis ___Goiter/Thyroid Disease ___Stroke
___Angina ___Crohn's ___ High Blood Pressure/Heart Disease ___Ulcer
___Asthma ___Diabetes ___Lupus/Rheumatoid Arthritis ___Whiplash

Other/Explain: ______________________________

Your family's history of certain conditions:

___Alcoholism ___Diabetes ___High Blood Pressure ___Osteoporosis
___Autoimmune (Lupus, M.S.) ___Emotional Disorders ___Migraines/Headaches ___Rheumatoid Arthritis
___Cancer ___Heart Disease ___Osteoarthritis ___Strokes

Other/Explain: ______________________________

Indicate names of all medications you <u>now use</u>: *i.e. <u>√</u> Anti-inflammatories <u>celebrex</u>*

___Anti-inflammatories ______________ ___Blood Thinners ______________
___Anti-depressants ______________ ___Heart Medications ______________
___Blood Pressure Meds ______________ ___Aspirin/Tylenol/Advil/OTC-Over The Counter

Other Medications: ______________________________

____

Past Medications: ______________________________

Indicate vitamins/minerals/herbs you now use: ______________________________

____

Have you taken any steps personally, beyond the above, to improve your health? Please list and indicate those which led to significant change: ______________________________

____

Do You Now:	**Yes**	**No**	**Please provide specifics**
Wear orthotic devices?			
Have insurance coverage for orthotics?			Details and amount of coverage:

Our centre is committed to conforming to federal privacy legislation effective January 1, 2004. All information collected is kept strictly confidential, unless the release of this personal information is authorized by yourself, the undersigned, or is required by law. I, the undersigned, believe that all information on this form is true to the best of my knowledge. Completion of this form authorizes the health care practitioner to perform a physical exam for the purpose of formulating a diagnosis and treatment plan.

Signature: ______________________ **Date:** ______________

PATIENT HISTORY FORM

Name: ____ **Date:** ________________________________

Please check √ any conditions or symptoms presently causing you problems.
Please put an **x** next to those conditions or symptoms that have been a problem for you in the past.

GENERAL SYMPTOMS:
Allergy
Chills
Convulsions
Dizziness
Fainting
Loss of consciousness
Fever
Headache
Loss of sleep
Nervousness
Depression
Neuralgia
Sweats
Loss of weight
Tremors
Numbness

MUSCLE & JOINT:
Neck stiffness
Neck pain
Low back pain
Mid back pain
Painful tail bone
Foot pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Arthritis
Bursitis
Loss of strength
Pain between shoulders
Sciatica
Swollen joints

GENITOURINARY:
Trouble urinating
Blood in urine
Painful urination
Frequent urination
Loss of control of urination
Kidney infection
Change in smell of urine
Bed wetting
Prostate trouble
Hernia

SKIN:
Rash/itching
Bruise easily
Dryness
Boils
Hives or allergy

RESPIRATORY:
Chest pain
Chronic cough
Difficulty breathing
Spitting blood
Spitting phlegm
Wheezing

CARDIOVASCULAR:
High blood pressure
Pain over heart
Angina
Stroke
Atherosclerosis
Varicose veins
Ankle swelling
Poor circulation
Slow or rapid heart beat

EYES, EARS, NOSE, THROAT:
Blurred vision
Loss of vision
Double vision
Eye pain
Loss of hearing
Ringing/buzzing in ears
Earache
Ear discharge
Asthma
Frequent colds
Sinus infection
Enlarged glands
Enlarged thyroid
Hoarseness
Nosebleeds
Slurring
Sore throat

GASTROINTESTINAL:
Poor appetite
Excessive hunger
Indigestion
Excessive gas
Nausea
Vomiting
Vomiting with blood
Pain in abdomen
Constipation
Diarrhea
Hemorrhoids
Jaundice
Liver trouble
Gall bladder trouble
Colitis/Chron's/IBS
Ulcers
Diabetes

PAIN OR NUMBNESS IN:
Shoulders
Arms
Hands
Hips
Legs
Knees
Ankles
Feet

LIFESTYLE HABITS:
Do you smoke?
☐ Yes ☐ No
Amount: ________________________________

Do you drink alcohol?
☐ Yes ☐ No
Amount: ________________________________

Do you regularly exercise?
☐ Yes ☐ No
Type: ___________________________________

Amount/Frequency: ______________________

____

FOR WOMEN ONLY:
Cramps
Heavy flow
Light flow
Irregular cycle
Painful cycle
Vaginal discharge
Hot flashes
Sore breasts
Lump in breast

Have you ever been on the birth control pill?
☐ Yes ☐ No

Are you currently taking the birth control pill?
☐ Yes ☐ No

Are you pregnant?
☐ Yes ☐ No
Due date: ________________________________
# of past pregnancies: ______________________

Are you menopausal?
☐ Yes ☐ No
Last menstruation: _________________________

File # ____________

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