

Chiropractic Health History and Entrance Form

A complete health history helps us ensure it is safe to provide you with a chiropractic treatment; please let us know if your status changes so we can update your form. All information given to us is confidential.

Name _____ Email _____

We collect your email address to send you appointment reminders. Your email address will never be shared with a third party.

Home Phone _____ Cell Phone _____ Work Phone _____

Street _____ Unit _____ City _____ Prov. _____ Postal Code _____

Date of Birth (MM-DD-YY) _____ Age _____ Occupation _____

How did you hear about us? _____

Do you have insurance coverage for Chiropractic Care? Yes No If yes, were you referred by your doctor? Yes No

Doctor's Name _____ Phone _____ Last Check-Up Date _____

Doctor's Street _____ Unit _____ City _____ Prov. _____ Postal Code _____

Have you had a chiropractic treatment before? Yes No If yes, approximate date of last chiropractic treatment _____

Do you see other healthcare practitioners? Massage Physio Naturopath Osteopath Other _____

Current Medications _____

Previous Major Illnesses/Operations (include dates) _____

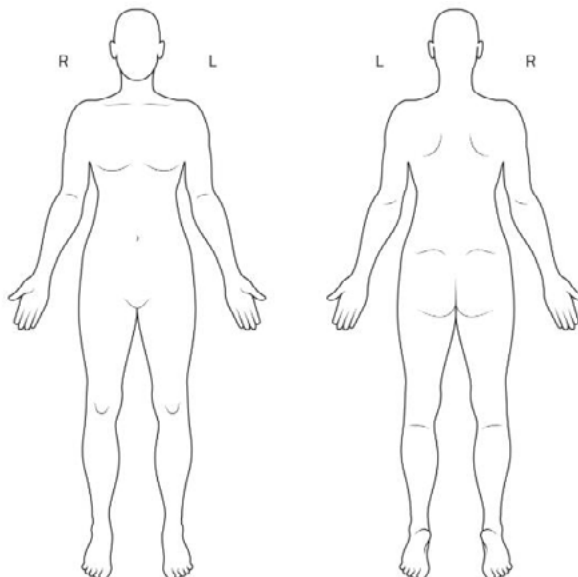
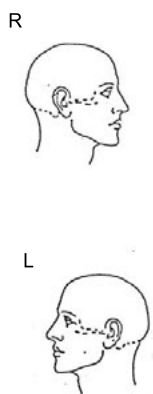
Allergies/Hypersensitivities _____

Family History of _____

Major Accidents (include dates) _____

Other Serious Medical Conditions _____

In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below. Please draw in the face on the diagram.



SYMBOLS:

- Numbness =====
- Burning xxxxxx
- Dull & aching ??????
- Pins and Needles ooooo
- Stabbing & Sharp ~~~~~
- Stiff & Tight 22222

For any **current** conditions or symptoms that are causing problems, please ✓ the box in the **C** column.
 For any **past** conditions or symptoms, please ✓ the box in the **P** column.

Gastrointestinal

- C P
 Poor appetite
 Indigestion
 Excess hunger
 Belching or gas
 Vomiting
 Pain over stomach
 Constipation
 Hemorrhoids (piles)
 Jaundice
 Gall bladder trouble
 Intestinal worms
 Ulcer
 Diabetes
 Diarrhea

Neurologic

- C P
 Dizziness
 Fainting
 Problem speaking
 Problem swallowing
 Blurred vision
 Double vision
 Clumsiness
 Numbness or tingling

Cardiovascular

- C P
 Bleeding disorder
 High blood pressure
 Chest pain
 Stroke
 Hardening of arteries
 Varicose veins
 Swelling of ankles
 Poor circulation
 Heart/blood disease
 Angina

Respiratory

- C P
 Asthma
 Chronic cough
 Spitting up phlegm
 Spitting up blood
 Difficulty breathing

General Symptoms

- C P
 Loss of Consciousness
 Blackouts
 Headache
 Fever
 Excess Sweating
 Night sweats
 Loss of Weight
 Night pain
 Generalized pain
 Convulsions

Genitourinary

- C P
 Trouble urinating
 Blood in urine
 Kidney infection
 Bedwetting
 Prostate trouble

Menstrual related

- C P
 Painful menstruation
 Excessive flow
 Hot flashes
 Irregular/absent cycle
 Cramping/backache
 Abnormal vaginal discharge
 Swollen breasts
 Lump in breasts

Have you had a bone density scan?

- Yes No

Currently on birth control?

- Yes No

Previously on birth control?

- Yes No

Number of pregnancies: _____

- Number of children: _____

Skin

- C P
 Rashes/itching
 Bruise easy
 Dryness
 Boils
 Hives (allergies)

Muscles & Joints

- C P
 Sore/stiff neck
 Low back pain
 Mid back ache
 Painful tailbone
 Shoulder pain
 Arm/forearm pain
 Elbow pain
 Wrists/hand pain
 Hip pain
 Knee pain
 Ankle/foot trouble
 Arthritis
 Loss of strength

Eyes/Ears/Nose/Throat

- C P
 Failing vision
 Eye pain
 Failing hearing
 Earache
 Ring/buzz in ears
 Frequent colds
 Sinus infection
 Enlarged thyroid
 Enlarged glands
 Nervousness
 Convulsions

Have you ever had any fractures?

- Yes No
 If yes - where? _____

Have you ever been in a car accident?

- Yes No
 If yes - when? _____

Have you ever been hospitalized?

- Yes No
 If yes – why/ when? _____

Have you ever been diagnosed with:

- Cancer Yes No
 HIV/AIDS Yes No
 Hep A/B/C Yes No

Have you ever had any mental health issues?

- C P
 Depression
 Anxiety
 Nervousness
 Trauma related condition
 Substance related condition
 Personality disorder
 Bipolar disorder
 Other (please list): _____

Medications (please list):

Clinician comments and signature:

Please read and sign:

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I understand that the Chiropractor can end treatment at anytime due to inappropriate behaviour.
- I consent to a health assessment/reassessments and chiropractic treatment at Massage Addict.
- I authorize Massage Addict to contact my doctor or other health care professional listed above if required for treatment purposes.
- I understand that all sessions include a pre-health assessment and change time.
- I understand 24 hours notice is required to reschedule all future appointments, or full charges will apply.
- I authorize my health file to be transferred to another Massage Addict clinic if I relocate or a new Massage Addict clinic opens closer to my household.

Signature _____ Today's Date _____

Updates to your health history are required every 6 months. A new health history form must be filled out every year.

Changes Yes No
 Comments _____

Signature _____

Changes Yes No
 Comments _____

Signature _____