Pure Health Chiropractic

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Patient History Form

Please fill out all 3 pages of this form regarding general and health information. If you have any questions, please feel free to ask.

General Information

Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Appointment reminder by Text/Email? ☐ Yes ☐ No

E-mail Address: _____

☐ Check here if you do not wish to receive email updates on events, health tips, etc.

Insurance Provider: _____ _____ AHC # : _____

☐ Employed Full Time ☐ Employed Part-Time ☐ Self Employed ☐ Retired ☐ Full Time Student ☐ Part-Time Student

Occupation: _____ Employer/School: _____

Birth Date (MM/DD/YYYY)_____ Height _____ Weight _____ Marital Status _____

How did you find out about Pure Health Chiropractic? _____

Emergency Contact Information

Name: _____ Phone: _____

Children:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Health Information

What are your present health objectives? _____

_____

Please list all medications you are currently taking _____

_____

Please check any of the following you have seen and the approximate time of your last visit:

☐ Chiropractor _____ ☐ Naturopath _____

☐ Massage Therapist _____ ☐ Acupuncturist _____

☐ Physiotherapist _____ ☐ Other _____

Please list all major surgeries and when they occurred:

□ Tonsils _____ □ Gall Bladder _____ □ Appendix _____

□ Hernia _____ □ Heart _____ □ Back _____

□ Neck _____ □ Other _____

Please list any Major Accidents or Falls: _____

_____

Please *check* any conditions which are *currently* causing you a problem.
Please <u>underline</u> any that have bothered you in the <u>past</u>.

General
□ Whiplash
□ Enlarged Glands
□ Loss of Weight
□ Hypoglycemia
□ Nervousness
□ Vision Problems
□ Hearing Problems
□ Frequent Colds or Flu

Nervous System
□ Vertigo
□ Loss of Feeling
□ Dizziness
□ Fainting
□ Headaches
□ Ringing in Ears
□ Confusion
□ Depression

Musculoskeletal System
□ Low Back Pain
□ Neck Pain
□ Arm Pain
□ Shoulder Pain
□ Elbow Pain
□ Wrist Pain
□ Leg Pain
□ Knee Pain
□ Foot Pain
□ Pain Numbness Radiating down arms or legs
□ Painful Tailbone
□ Pain between shoulders
□ Scoliosis
□ Arthritis
□ Walking Problems
□ Difficulty Chewing
□ Clicking Jaw
□ Ankle Swelling
□ Orthopedic Problems

Body System
□ Frequent Urination
□ Painful Urination
□ Blood in Urine
□ Kidney Stones
□ Prostate Problems
□ Anemia
□ Hypothyroid
□ Hyperthyroid
□ Gas/Bloating
□ Constipation
□ Diarrhea
□ Colitis
□ Black/Bloody Stool
□ Hemorrhoids
□ Liver Trouble
□ Gall Bladder Trouble
□ Eczema
□ Psoriasis
□ Asthma
□ Shortness of Breath
□ Heart Problems

Please *check* any of the following you have experienced:

□ Alcoholism
□ Arthritis
□ Rheumatic Fever
□ Allergies
□ Venereal Infection
□ Stroke
□ Diabetes
□ Heart Disease
□ Epilepsy
□ Tuberculosis
□ Cancer
□ High Blood Pressure

STRESS TEST

For the following, please check off the level you are currently experiencing, and <u>underline</u> which you have experienced in the past.

	None	Light	Moderate	Heavy
GENERAL:				
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Energy Level	☐	☐	☐	☐
CHEMICAL STRESS:				
Caffeine	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Junk Food	☐	☐	☐	☐
Prescription Drugs	☐	☐	☐	☐
Over the Counter Drugs (Tylenol, Advil, etc)	☐	☐	☐	☐
Environmental Pollution (Air, Water, etc.)	☐	☐	☐	☐
EMOTIONONAL STRESS:				
Relationships	☐	☐	☐	☐
Career	☐	☐	☐	☐
Money	☐	☐	☐	☐
Verbal Abuse	☐	☐	☐	☐
Internalized Feelings	☐	☐	☐	☐
Quick Temper	☐	☐	☐	☐
PHYSICAL STRESS:				
Birth Trauma	☐	☐	☐	☐
Slips / Falls	☐	☐	☐	☐
Sports Injuries	☐	☐	☐	☐
Poor Posture	☐	☐	☐	☐
Carrying Heavy Objects	☐	☐	☐	☐
Repetitive Motions	☐	☐	☐	☐
Continuous Sitting	☐	☐	☐	☐
Physical Abuse	☐	☐	☐	☐
Car Accidents (How many? _____)	☐	☐	☐	☐
Work Injuries (How many? _____)	☐	☐	☐	☐
Sleeping Position (Stomach)	☐	☐	☐	☐

Which do you feel is your primary Stress? ☐ CHEMICAL ☐ EMOTIONAL ☐PHYSICAL

Explain: _____

_____

_____