Pure Health Chiropractic

Patient Health History Form

Personal Information

Name:_____ Hm. # _____ Cell # _____
Address_____ Postal Code:_____
Birth date: month_____ day_____ year_____Age_____ Sex: M / F
Occupation_____ E-mail Address_____
Alberta Health Care # _____ Height_____ Weight_____
Do you have health care benefits for Chiropractic? ☐Yes ☐No

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

Is this injury the result of a motor vehicle accident or work-related accident?
If Yes, please list:_____
Have you had previous chiropractic care? ☐Yes ☐No Doctor's name: _____ How long ago?_____
Have you received X-rays in the last 2 yrs.? ☐Yes ☐No Area x-rayed_____
Name of Family Medical Doctor_____ Others seen for this condition_____
Emergency Contact Name: _____ **Emergency Contact Number**: _____

Please Check Any of the Following that Apply to You:

☐Sleeping Problems	☐Dizziness	☐Headaches	☐Fevers
☐Bowel Problems	☐Hypoglycemia	☐Heartburn	☐Chronic Fatigue syndrome
☐Nervousness	☐ADHD	☐Hot Flashes	☐Depression
☐High Blood Pressure	☐Difficulty Breathing	☐Seizures	☐TMJ/Jaw Pain
☐Ulcers	☐Poor Concentration	☐Menstrual Pain	☐MS
☐Frequent Colds	☐Problem Urinating	☐Mood swings	☐Fibromyalgia
Pins & Needles in: ☐legs/feet ☐arms/hands	☐Lack of / low energy ☐Poor Awakening	Numbness in: ☐Feet/Toes ☐Hands/fingers	☐Auto-immune system disorders ☐Epstein-Barr syndrome
☐Heart Palpitations	☐Buzzing/ringing ears	☐Bed Wetting	☐Ear Aches
☐Cold hands/feet	☐Loss of Taste/Smell	☐Panic Attacks	☐Loss of Balance
☐Neck Pain/stiffness	☐Irritability	☐Allergies	☐Rheumatoid Arthritis

Your Injury History:

1. What is your major reason for consulting our office? _____
2. How long has this been going on? ☐Days ☐Weeks ☐Months ☐Years

   How did it originally occur? _____
3. What specific life activities does it interfere with (work, sleep, leisure, etc.)? _____

   Has it become worse recently? ☐Yes ☐No ☐Same ☐Better ☐Gradually Worse

   If yes, when and how? _____
4. How frequent is the condition? ☐Constant ☐Daily ☐Intermittent ☐Night Only
5. Is there anything you can do to relieve the problem? ☐Yes ☐No

   If yes, describe: _____

   If no, what have you tried to do that has not helped? _____
6. What makes the problem worse? ☐Standing ☐Sitting ☐Lying ☐Bending ☐Lifting ☐Twisting

   Other _____
7. Describe the pain: ☐Sharp ☐Dull ☐Numbness ☐Tingling ☐Aching ☐Burning ☐Stabbing

   Other _____

   Does the pain travel or radiate? ☐Yes ☐No If Yes, where? _____
8. Are there other unrelated health problems? ☐Yes ☐No If yes, describe_____

   _____

9. Have you had any broken bones? ☐Yes ☐No Please list _____

10. To your knowledge, have you had any diseases, major illnesses, or injuries not indicated on this form either in the past or the present? ☐Yes ☐No If yes, please explain _____

11. To your knowledge, is there a family history of cancer, stroke, diabetes, heart disease or a spinal condition? ☐Yes ☐No If yes, please explain _____

_____

11. List any medications you are taking: _____

Please place an "X" and assign a number 0-10 on the line below to indicate level of problem.

NO SYMPTOMS 0 I----------I 10 EXTREME SYMPTOMS

Your Health Profile

Spinal subluxations have a significant impact on your health and well-being. Please answer the following important questions to the best of your ability, in as much detail as possible.

Physical Stress

☐Yes ☐No Have you ever been involved in a motor vehicle accident (even if you were not injured)? If yes, please describe: _____

☐Yes ☐No Have you had any falls or accidents (especially hard falls, sports/car accidents, concussions, broken bones, etc.)? If yes, please list all: _____

☐Yes ☐No Do you currently play any sports?

☐Yes ☐No Have you had any sports injuries? If yes, please describe: _____

☐Yes ☐No Were you under regular Chiropractic care as a child?

☐Yes ☐No Does your job require lifting, repetitive motions, or excessive standing or sitting?

☐Yes ☐No Have you had any surgeries? Please list all: _____

Nutritional Stress

☐Yes ☐No Do you eat 12 to 15 servings of vegetables/fruits daily?

☐Yes ☐No Do you take a multivitamin? Which brand? _____

☐Yes ☐No Do you supplement with a greens powder? Which brand? _____

☐Yes ☐No Do you take omega 3 / fish oil / cod liver oil? Which brand? _____

☐Yes ☐No Do you take 4,000-5,000 IU of Vitamin D daily? Which brand? _____

☐Yes ☐No Do you take a probiotic? Which brand? _____

Emotional Stress

On a scale from 1 (best) → 10 (worst), rate your current stress level of the following:

Work _____ Home _____ Financial _____ Other _____

Please describe the following as either poor, fair, good or excellent:

Diet _____ Exercise _____ Sleep _____ General Health _____

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Doctor's Signature _____ Date _____