

Patient History Form

Please fill out both 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 SMS/Text Message? Yes No Cell phone provider: Bell Roger's Telus Fido Virgin
 Appointment reminder by E-Mail? Yes No E-mail Address: _____
 Employed Full-Time Employed Part-Time Self-Employed Retired Full-Time Student Part-Time Student
 Occupation: _____ Employer/School: _____
 Birth Date _____ 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? _____

Name/Address/Phone of the last doctor who put you on a health development program _____

Were you able to stay on the program? Yes No How Long? _____

What were your results? _____

Were your results permanent? Yes No Are you healthier today than you were 5 years ago? Yes No

If so, what did you do to improve your health? _____

If not, why do you think your health declined? _____

Will you be healthier 5 years from now than you are today? Yes No

If so, what are you planning to do to improve you health? _____

If not, what could you do to improve your health rather than have it continue to decline? _____

What would you like your health to be like 5 years from now? _____

Name of any physicians and specialists you are currently consulting _____

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 underline any that have bothered you in the past.

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
- Upper Back Pain
- Middle Back Pain

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

Please rate your current level or consumption of the following:

	None	Light	Moderate	Heavy
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Junk Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>