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 EXTREME
SYMPTOMS 0 I----------I 10 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 Greens powder? Which brand? _____

☐ Yes ☐ No Do you take Omega3 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) to 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 _____

Doctor's Signature _____ Date _____