

Centrum Chiropractic and Acupuncture

#116-210 Centrum Blvd. Ottawa K1Z-5M9 (613) 830-4080

Web: www.centrumchiro.com

Email: health4you@bellnet.ca



Adolescent and Adult Health History Form

Personal Information

Name: _____ Date: _____ Patient Number: _____
Age: _____ Height: _____ Weight: _____ Birth date: _____ (dd/mm/yyyy)
Sex: M F
Address: _____ City: _____ Postal Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email Address: _____ I am interested in receiving e-newsletters
Marital Status: Single Married Widowed Divorced Common Law
Whom may we thank for referring you? _____
Emergency Contact: (Name) _____ Phone Number: _____

Why This Form is Important

Our mission is to empower individuals to perform optimally so that they may become self aware, strong and healthy and enjoy improved adaptation to everyday stresses. Completion of this form provides us with a better understanding of your physical, emotional and chemical stresses that can gradually overwhelm the body over time contributing to health problems. Please complete this form as thoroughly as possible and the doctor will review it with you.

If there are no current concerns and this assessment is to ensure optimum health, function and wellness, select this box.

Health Concern: _____

If pain is involved, rank it on a scale of 1 to 10 (1 is minimal, 10 is extreme) 1 2 3 4 5 6 7 8 9 10

Circle or describe it's character:

Sharp, dull, ache, burning, tingling, throbbing, spasm _____

When did you first notice it? _____

What happened? _____ How often does it occur? _____

What relieves it? _____ What aggravates it? _____

Does it radiate or cause problems somewhere else? _____

Any associated or related concerns? _____

Other professionals seen for this: _____

Treatment and results: _____

Family doctor's name: _____ Address: _____

Recent tests done (list date beside): Bloodwork _____ Urine _____ X-Rays _____

Other Health Concerns

Please note all other health concerns present or in the past. Check applicable boxes.

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lowered resistance | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Difficulty concentrating |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Bloating | <input type="checkbox"/> Appendicitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Vision changes | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Difficult digestion | <input type="checkbox"/> Migraines | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Constipation | <input type="checkbox"/> Loose stools |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Pinched nerve | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Fertility problems | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Thyroid problem | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Numbness and tingling |
| <input type="checkbox"/> Pins and needles | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Menstrual pain and cramping |
| <input type="checkbox"/> Stroke | | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Ulcerative colitis | | | |
| <input type="checkbox"/> Frequent colds | | | |

Other: _____

Women: Are you pregnant? Yes No Unsure

Physical Stresses

Any significant injuries, falls or traumas during infancy or childhood? Yes No Unsure

If yes please explain:

Any significant injuries, falls or traumas during adulthood? Yes No Unsure

If yes please explain:

Any hospital visits? Yes No Have you had any surgeries, fractures, car accidents? Yes No

If yes please explain and list dates:

Are you in prolonged postures? (ie: repetitive work, lifting, sitting, driving) Yes No Unsure

If yes please explain:

Any hobbies that are physically strenuous or have repetitive movements? Yes No Unsure

If yes please explain:

What is your exercise level? Low Moderate Daily Heavy

What is your usual exercise routine?

What position do you sleep in? Back Side Stomach

For how many hours?

Any fractured bones or dislocations?

Any vehicle accidents? Yes No What happened and when?

Chemical Stresses

Are you taking prescription or over-the-counter medications? Yes No

If yes please explain what you are taking and why: _____

Are you currently taking supplements? Yes No

If yes please explain what you are taking and why:

Do you smoke? Yes No I Quit If yes, how much:

Do you drink alcohol? Yes No If yes, approximately how much:.

Are you happy with your diet? Yes No Do you wish assistance with it? Yes No

Do you drink bottled water? Yes No Occasionally

Are you exposed to pollutants, strong smells, chemicals, aerosols? Yes No Occassionally

Mental/Emotional Stresses

As psychological stress has been shown to negatively affect nervous system function, please let us know how you are coping with life's stresses. Rank from 1 to 10 with 1 being minimal to 10 being extreme,

Life in general I feel 1 2 3 4 5 6 7 8 9 10 Work and Career I feel 1 2 3 4 5 6 7 8 9 10

Relationships I feel 1 2 3 4 5 6 7 8 9 10 Financial stress I feel 1 2 3 4 5 6 7 8 9 10

Time management I feel 1 2 3 4 5 6 7 8 9 10 Sports & hobbies I feel 1 2 3 4 5 6 7 8 9 10

Quality of sleep I feel 1 2 3 4 5 6 7 8 9 10 Health/well-being I feel 1 2 3 4 5 6 7 8 9 10

If you are experiencing significant or ongoing stress please explain:

Family Health History

Please note any health issues that are present with family members such as parents, siblings, significant other or children.

Cancer Hypertension Stroke Arthritis Kidney disease Dementia Diabetes

Other: _____

Why You are Here

People seek chiropractic care for a number of reasons and have certain expectations and perceptions.

Please check the goals that apply to you so we can accommodate your wishes.

- Improvement in function
 - Pain reduction
 - Improved quality of life
 - Manage my crisis
 - Wellness
 - Symptom management
 - Healthier immune system
 - Stress reduction
 - Keep me moving
 - Relief
 - Improved performance
 - Longevity
 - Full body integration
 - Information on prevention
 - Optimum function and quality of life
 - Other: _____
-