8th Street Chiropractic
HEALTH & WELLNESS CLINIC

Confidential Patient Information

Full Name: _____ **Date:** _____

DOB: _____ **Age:** _____ **HSN:** _____ **Exp:** _____

Address: _____ **City:**_____ **Prov:** _____ **Postal Code:** _____

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

Email Address: _____ **Occupation:** _____

Height: _____ **Weight:** _____ **Are you currently pregnant?** □ **Yes** □ **No**

Name of Family Doctor:_____ **Date of Last Physical Exam:** _____

Is this appointment for a: □ **Work injury?** □ **Motor Vehicle Accident?**

Whom may we thank for referring you? _____

General Health History

Have you been diagnosed with any of the following?

□ **Diabetes** □ **Stroke** □ **Other** _____
□ **High Blood Pressure** □ **Transcient Ischemic Attacks**
□ **Fibromyalgia** □ **Arthritis**
□ **High Cholesterol** □ **Cancer** **Type?** _____

Have you had any surgery? (Please include all surgery)

1. **Type:** _____ **When:** _____
2. **Type:** _____ **When:** _____
3. **Type:** _____ **When:** _____
4. **Type:** _____ **When:** _____

Have you been involved in any work related, automobile or other significant personal injury?

1. **Type:** _____ **When:** _____
2. **Type:** _____ **When:** _____
3. **Type:** _____ **When:** _____
4. **Type:** _____ **When:** _____

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating Habits: _____ **Exercise habits:** _____ **Sleep:** _____ **Energy:** _____ **General Health:** _____

Do you exercise regularly? □ **Yes** □ **No** **Describe:** _____

Have you had previous chiropractic care? □ **Yes** □ **No** **When?** _____ **Doctor's Name:** _____

For what condition? _____

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Patient Name: _____

How would you describe your physical health?
□ Excellent □ Good □ Fair □ Poor

How would you describe your emotional/mental health?
□ Excellent □ Good □ Fair □ Poor

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past six months: (prescription and non-prescription):

□ Pain Killers
□ Muscle Relaxants
□ Aspirin
□ Cholesterol Lowering Drugs
□ Other _____
□ Corticosteroids
□ Anticoagulants/Blood thinners
□ Birth Control Pills
□ Antidepressants

Please list all nutritional supplements and vitamins you presently take:

□ Multivitamin
□ Vitamin C
□ B Vitamins
□ Digestive enzymes
□ Other _____
□ Omega 3 oils
□ Coenzyme Q10
□ Calcium/Magnesium

We sell a selection of the highest quality professional supplements at minimal markup. Would you take supplements if indicated?
□ Yes □ No □ Maybe

If specific exercises would improve your health, would you consider adding them to your daily activities?
□ Yes □ No □ Maybe

How many hours a day do you spend at the computer, TV or mobile media?

Weekdays_____ Weekends _____

How many hours do you sit each day (including work and home)?
Weekdays _____ Weekends _____

On a scale of 1-10 (1 being very low and 10 being extremely high) please grade your present levels of stress:
Occupational _____ Personal _____

Please check any symptoms you have experienced during the past 12 months:

Gastrointestinal
□ Indigestion
□ Ulcers
□ Heartburn
□ Constipation

Neurological
□ Visual disturbances
□ Coordination difficulties
□ Dizziness
□ Slurred speech
□ Poor Posture

Respiratory
□ Chronic cough
□ Chest pain
□ Difficulty breathing
□ Asthma
□ Sleep apnea

Muscle and Joints
□ Neck pain and/or tightness
□ Mid and upper back pain
□ Low back pain and/or tightness
□ Lower limb joint pain
□ Upper limb joint pain

Cardiovascular
□ High blood pressure
□ Hardening of arteries
□ Swollen Ankles
□ High Cholesterol

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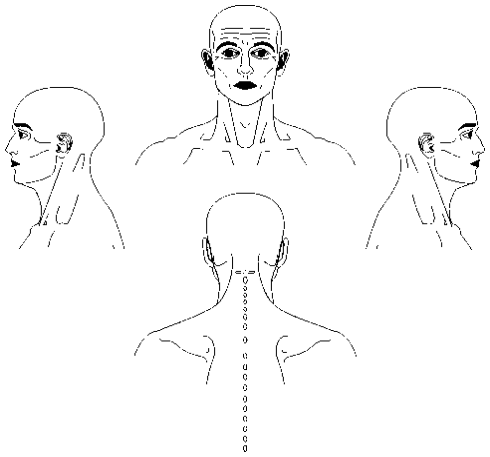
Patient Name: _____

Do you experience headaches? □ No □ Yes

Please mark the area of headache pain on the diagram:



How long have you experienced headaches?
Weeks ____ Months ____Years _____

How frequent have the headaches been during the last 6 months?
 # each week _____ # each month _____

What time of day do the headaches occur? _____

Has there been any recent increase in severity, frequency or duration of the headaches? □ No □ Yes
Describe: _____

Do the headaches interfere with:
□ Work □ Leisure activities □ Quality of life

What do you think is the cause of the headaches?
_____

_____

_____

Have you received a diagnosis for the headaches? □ No □ Yes
If yes, what was the diagnosis?
□ Migraine
□ Cluster
□ Tension type
□ Sinus
□ Temporal arteritis

Do you take over the counter or prescription medications for the headaches?
Type: _____# per day ____# per week_____

Type: _____# per day ____# per week _____

Do the medications help? □ Not really □ Yes, mild relief □ Yes, moderate relief □ Yes, total relief

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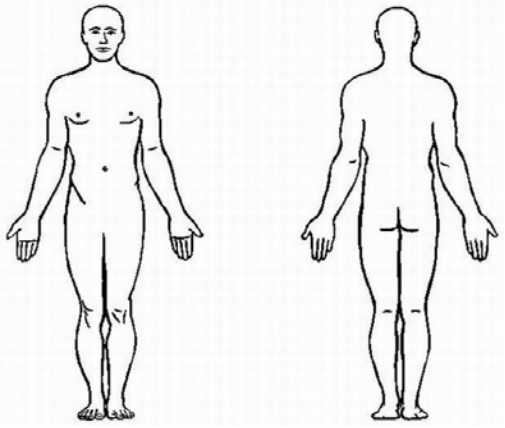
Patient Name: _____

Please mark your areas of concern on the figure below:



Primary reason for consulting the clinic:

_____

How long have you had your primary complaint? _____

How did it start? _____

Is it:
□ **Improving** □ **Staying the same**
□ **Getting worse** □ **Comes and goes**

Is it worse in the:
□ **Morning** □ **Afternoon**
□ **Evening** □ **Night**

Does it interfere with: □ **Work** □ **Sleep** □ **Hobbies** □ **Sports/Exercise**
□ **Other (explain)** _____

What makes it worse? (e.g. sitting/standing/lifting)

_____

What makes it better? (e.g. rest/ice/heat)

_____

Are you taking prescription or over the counter medication for the symptoms? □ **Yes** □ **No**
Type: _____
 # per day _____ **# per week** _____
Type: _____
 # per day _____ **#per week** _____

Have you seen any of the following for this condition?
□ **Chiropractor** □ **M.D.**
□ **Massage Therapist** □ **Specialist**
□ **Physical Therapist** □ **Other** _____

Have you had spinal X-rays? □ **Yes** □ **No**
When? _____

To further evaluate some conditions, X-rays are required.
Do you consent to any necessary radiographic studies?
□ **Yes** □ **No** □ **Maybe**

Is there anything else which may help to better understand you or your health challenge which has not been discussed?

_____

_____