

West Edmonton Family Chiropractic

Chiropractic History Form

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your chiropractor will outline a course of care to correct these layers of damage and recover your innate potential.

Name: _____ Date: _____ AHC #: _____

Address: _____ City/Prov: _____ Postal Code: _____

Home #: _____ Cell #: _____ Work #: _____

Age: _____ Birthday: (mm/dd/yr) _____ Gender: M or F Height: _____ Weight: _____

Occupation: _____ Marital Status: M S W D Spouse/Partner's Name: _____

Children's Name(s): _____ Who may we thank for referring you to our office? _____

Have you had previous chiropractic care? Y N Chiropractors Name: _____

When? _____ For how long? _____ Reason: _____ Were x-rays taken? Y N When? _____

Would you like to receive email appointment reminders? Y N Email address: _____

PRESENT STATE OF HEALTH

What is your reason for coming to our office? Wellness Maintenance Specific Symptom

If you are here for a specific symptom, what is your major complaint presently? _____

How long have you had this condition? _____ Have you had a similar condition in the past? _____

What activities aggravate your condition? _____

What relieves your condition? _____

Is your condition getting progressively worse? Yes No It's constant It comes and goes

Pains are: Sharp Dull Burning Tight Throbbing

Is this condition interfering with your: Work Daily Routine Other _____

Have you seen anyone else for this condition? _____

Please check (v) all Symptoms that you have ever had, even if they do not seem related to your current problem.

(P=Past/C=Current in last 6 months)

Headaches

Pins and needles in leg

Fainting

Neck pain

Pins and needles in arms

Loss of smell

Back Pain

Loss of balance

Dizziness

Buzzing in ears

Ringing in ears

Nervousness

Numbness in fingers

Numbness in toes

Loss of taste

Stomach upset

Fatigue

Depression

Irritability

Tension

Sleeping problems

Neck stiffness

Cold hands

Cold feet

Diarrhea

Constipation

Fever

Hot flashes

Cold sweats

Light bothers eyes

Problem urinating

Heartburn

Mood swings

Menstrual pain

Menstrual irregularity

Ulcers

Other _____

CHILDHOOD HEALTH HISTORY

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Certain stresses in your life start to produce layers of damage to your spine and nerve system. Please answer the following questions to the best of your ability.

Were there complications during your delivery? Y N Unsure
Was any form of birth interventions used? Forceps Cesarean Breech Other: _____
Were you involved in any car accidents as a child? Y N Unsure Year: _____

Your feeding history: Breast Feed Y N How long? _____
Formula Feed Y N How long? _____
Food Allergies or Intolerances? Y N List: _____

Did you have any childhood illnesses? Y N Unsure
List: _____ Did you suffer any other traumas? Y N Unsure
(physical or emotional)? List: _____

Did you have any surgery? Y N Unsure
List: _____ Was there prolonged use of drugs? Y N Unsure
(antibiotics, inhalers, etc.)
List: _____

Were you vaccinated? Y N Unsure
What vaccinations? _____ Age given? _____

According to the National Safety Council, approximately 50% of children fall head first from a high place during the first year of life (i.e., a bed, changing table, down the stairs, etc.)

Did you have any serious falls as a child? Y N Unsure

Were you involved in any high impact or contact sports as a child? Y N List: _____

Any other traumas not described above? Y N List: _____

As a child were you under regular Chiropractic care? Y N Unsure

ADULT HEALTH HISTORY

Do/did you smoke? Y N Do/did you take medications? Y N
How often? _____ What & When? _____
When did you quit? _____

Do/did you drink alcohol? Y N Do/did you participate in adult sports? Y N
How often? _____ What? _____

Have you been in any car accidents? Y N Do/did you wear: Heel Lifts Sole Lifts
When? _____ Inner Soles Arch Supports

Have you had any surgeries? Y N On a scale of 1-10 describes your stress level:
What & When? _____ (1=none / 10-extreme)
Occupational _____
Personal _____

Have you suffered any other traumas Y N
(physical or emotional)?
List: _____ Is there a possibility that you may be pregnant? Y N

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Others: _____

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you feel more comfortable. We look forward to working with you to improve your health.
