

# 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 (√) all symptoms you have ever had, even if they do not seem related to your current problem.

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

P	C	P	C	P	C	P	C
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches		Pins and needles in legs		Fainting		Neck Pain	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pins and needles in arms		Loss of smell		Back pain		Loss of balance	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness		Buzzing in ears		ringing in ears		Nervousness	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness in fingers		Numbness in toes		Loss of taste		Stomach upset	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue		Depression		Irritability		Tension	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping problems		Neck stiffness		Cold hands		Cold feet	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea		Constipation		Fever		Hot flashes	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sweats		Lights bother eyes		Problem urinating		Heartburn	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings		Menstrual Pain		Menstrual irregularity		Ulcers	
<input type="checkbox"/>	<input type="checkbox"/>						
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 you involved in any car accidents as a child? Year: \_\_\_\_\_ Y N Unsure

Was your birth difficult? Forceps/Cesarean/Breech/Other: \_\_\_\_\_ Y N Unsure

Did you suffer any other traumas (physical or emotional)? List: \_\_\_\_\_ Y N Unsure

Did you have any childhood illnesses? List: \_\_\_\_\_ Y N Unsure

Was there prolonged used of drugs (antibiotics, inhalers, etc) List: \_\_\_\_\_ Y N Unsure

Did you have any surgery? List: \_\_\_\_\_ Y N Unsure

Were you vaccinated? Y N Unsure

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

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

Did you play youth sports? List: \_\_\_\_\_ Y N

Was your birth difficult? Forceps / Cesarean / Breech / Other: \_\_\_\_\_ Y N Unsure

## ADULTHOOD HEALTH HISTORY

Do/did you take medications? Y N  
What & when? \_\_\_\_\_  
\_\_\_\_\_

Do/did you wear:  Heel Lifts  Sole Lifts  
 Inner Soles  Arch Supports  
When? \_\_\_\_\_

Is there a possibility that you may be pregnant? Y N

Do/did you smoke? Y N  
How often? \_\_\_\_\_  
When did you quit? \_\_\_\_\_

Do/did you drink alcohol? Y N  
How often? \_\_\_\_\_

Have you been in any car accidents? Y N  
When? \_\_\_\_\_

Have you had any surgeries? Y N  
What & when? \_\_\_\_\_

Have you suffered any other traumas (physical or emotional)? Y N  
List: \_\_\_\_\_

Do/did you participate in adult sports? Y N  
What? \_\_\_\_\_

On a scale of 1 – 10 describe your stress level:  
(1 = none / 10 = extreme)

Occupational \_\_\_\_\_  
Personal \_\_\_\_\_

## 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.