Burlington Chiro Natural Health & Wellness Centre
1960 Appleby Line, Suite 25, Burlington, Ontario L7L 0B7
www.BurlingtonChiro.ca
(905) 332-7447

DATE: _____

Confidential Patient Health Record

PERSONAL HISTORY

LAST NAME: _____ FIRST NAME: _____ HOME PHONE: _____

HOME ADDRESS: _____ CITY/PROVINCE: _____ POSTAL CODE: _____

BIRTH DATE: _____ AGE: _____ M or F OCCUPATION: _____

BUSINESS PHONE: _____ MARITAL STATUS: _____ NAME OF SPOUSE: _____

WHO IS LEGALLY RESPONSIBLE FOR THIS ACCOUNT? _____

NAME AND AGES OF CHILDREN (Under age 25): _____

HOW DID YOU HEAR ABOUT OUR OFFICE? INTERNET (Circle one) General Google Search, Milton Directory, Other_____
LOCATION_____ WALK-IN_____ REFERRAL (BY WHOM?)_____

EMAIL ADDRESS: _____

HEALTH INFORMATION

HOW LONG HAS IT BEEN SINCE YOU FELT REALLY GOOD? _____

PLEASE LIST ANY SURGICAL OPERATIONS: _____

DRUGS YOU ARE CURRENTLY TAKING: BIRTH CONTROL PILLS INSULIN MUSCLE RELAXANTS PEP PILLS
PAIN KILLERS ANTI-INFLAMMATORIES ANTI-DEPRESSANTS VITAMINS

OTHER MEDICATIONS: _____

NAME OF MEDICAL DOCTOR: _____

AGE OF MATTRESS: _____ COMFORTABLE UNCOMFORTABLE
HOW DO YOU SLEEP? ON BACK ON SIDE ON STOMACH A COMBINATION

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? NO YES HOW MANY? _____ DATES: _____

HAVE YOU HAD ANY OTHER PERSONAL INJURY? PAST YEAR PAST 5 YEARS OVER 5 YEARS NONE
or WORK-RELATED ACCIDENT? (DESCRIBE) _____

DO YOU SMOKE OR USE TOBACCO? NO YES HOW MUCH PER DAY? _____
DO YOU DRINK ALCOHOL? NO YES HOW MUCH PER WEEK? _____
DO YOU USE NARCOTIC DRUGS? NO YES

WHAT EXERCISE DO YOU PARTICIPATE IN? _____ HOW MUCH PER WEEK? _____

DO YOU WEAR A HEEL LIFT OR ORTHOTIC INSOLES? NO YES

PREVIOUS CHIROPRACTIC CARE: NO YES DOCTOR'S NAME AND DATE OF LAST VISIT: _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING YOU HAVE HAD:

- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diptheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczema

CHECK ANY OF THE FOLLOWING YOU **HAVE** OR **HAVE HAD** IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Difficult Chewing/Clicking jaw

NERVOUS SYSTEM CODE

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

GENERAL CODE

- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ Weight Changes
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling

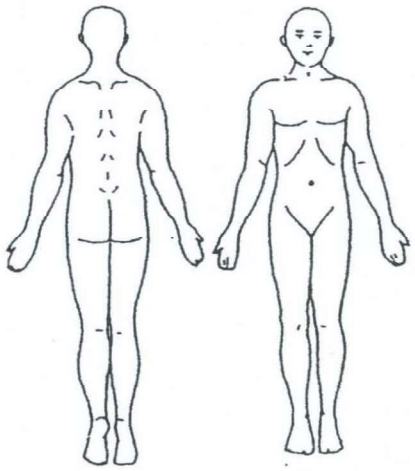
EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE/FEMALE CODE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes

Please outline in the diagram the area of your discomfort.



FEMALES ONLY:

When was your last period? _____

Are you pregnant? ☐ Yes ☐ No ☐ Maybe

CURRENT HEALTH CONDITIONS

List 3 complaints below and answer the following questions regarding each. List your primary complaint as #1.

List your complaint(s) here:	1. _____	2. _____	3. _____
a. When did you first experience this problem?			
b. How did this problem first begin?			
c. How often do you experience this problem?			
d. Rate intensity of this problem: (1 = mild; 10 = extreme) - At its best	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
- At its worst	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10
e. Describe how it feels (eg achey, burning, stabbing, sharp, etc.):			
f. Describe the location of pain:			
g. What makes it better?			
h. What makes it worse?			
i. Does the pain radiate to other areas? If yes, explain where.			
j. Is this problem getting better, worse or staying the same?	better worse same	better worse same	better worse same
k. What time of day does this problem affect you the most?			
l. What have you tried to do to relieve this problem? (previous treatments)			
m. Have you seen other doctors for this problem (if yes, list)?			

List any known allergies: _____

Have you ever been tested for food allergies? no yes (if yes, list) _____

LIFESTYLE AND SOCIAL HISTORY

Job Description: _____

Work Hours per week ____ Occupational Stress Level (1-10) ____ Personal Stress Level (1-10) ____

Recreational Activities: _____

Circle all that apply: smoke cigarettes – drink alcohol – drink coffee – exercise regularly – get enough sleep