New Patient Health History Form

Patient Data

First Name _____ Last Name_____Sex: __M__F Date_____E-Mail_____

*Your e-mail will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions.

Mailing Address

Address_____City_____Province_____Postal Code_____

Telephone(home)_____(work)_____(Cell)_____

Age_____Birth Date (dd/mm/yr)_____**Alberta Health Care#**_____

Occupation_____Employer_____

Single_____Married_____Spouse's Name_____Number of Children_____

Childrens Names:_____

Medical Doctor_____Date of Last Physical_____

Reason for consulting our practice: □ Chiropractic □ Laser Therapy □ Massage

Whom may we thank for referring you to our office?_____

Emergency Contact_____

Current Complaints

Reason for your visit/ chief complaint?_____

Nature of Injury/Condition: □ Automobile □ Work Injury □ Other

What day did it start?_____How did it start?_____

Pains are: □ Sharp □ Dull □ Constant □ Intermittent □ Numbness/Tingling

What makes your pain/condition worse?_____

Is it worse at any time during the day?_____

What makes your pain/condition better?_____

How often do you feel it? □Constant ____times per: day / week / month / year

Does the pain radiate (travel)? □Yes □No Where_____

Does the pain interfere with: □ Work □ Sleep □ Daily Routine □ Other

Have you had this problem before? □Yes □No Did it get Better? □Yes □No

Have you had X-Ray's of the area of concern? □Yes □No Where?_____

What previous treatment have you had for this pain/condition?_____

Did the previous treatment help? □Yes □No

Please rate your pain by:

1) Circle **TWO numbers** that best describes your pain at its **BEST** and at its **WORST** this **past week.**

0 1 2 3 4 5 6 7 8 9 10

No Pain Intolerable pain

2) Circle the **ONE number** that best describes how pain has interfered with general activity this **past week.**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere Completely Interferes

Patient Name_____**Date**_____**Chart #**_____

Relevant Health History	Yes	No	Patient Comments
Any recent steroid injections?	○	○	
Exercise regularly?	○	○	
Females: Are you pregnant?	○	○	
Broken any bones?	○	○	
Been in an auto accident?	○	○	
Had sprains/strains?	○	○	
Been struck unconscious?	○	○	
Have you had Surgery?	○	○	
Do you wear orthotics?	○	○	
Do you take vitamin supplements? List:	○	○	

Circle all the conditions you have ever had, even if they don't seem related:			
Blood Clots	Headaches	Pins & needles in legs	Constipation
Hepatitis	Stiff Neck	Pins and needles in arms	Diarrhea
Circulation Problems	Neck pain	Buzzing/ringing in ears	Stomach upset
Heart Disease	Dizziness	Numbness in toes	Ulcers
Seizures	Fatigue	Numbness in fingers	Heartburn
Diabetes Type_____	Sleeping problems	Fainting	Problems urinating
Arthritis/ Fibromyalgia	Cold Sweats	Light Bothers eyes	Cold hands/feet
Osteoporosis	Mood Swings	Loss of balance	Tension
Cancer	Depression	Loss of smell	Females: hot flashes
Herpes/ HIV	Irritability	Loss of taste	Menstrual pain
Back pain	Nervousness	Fever	Menstrual irregularity

List all medications you are currently taking and for what condition: (or attach a list)

Do any of the medications you are taking require you to stay out of direct sunlight?

Family History

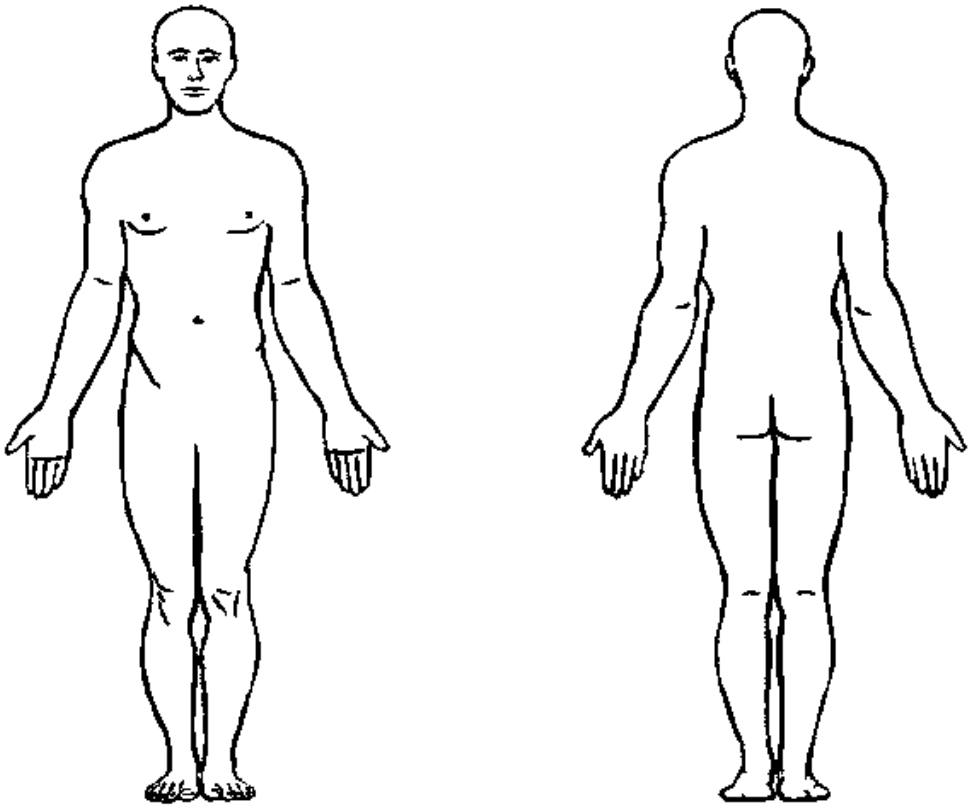
Family members – Present and past health conditions
(Example: heart disease, cancer, diabetes, stroke, arthritis, etc.)

Habits	None	Light	Moderate	Heavy
Alcohol	○	○	○	○
Tobacco	○	○	○	○
Coffee	○	○	○	○
Drugs	○	○	○	○
Exercise	○	○	○	○
Sleep	○	○	○	○
Appetite	○	○	○	○
Soft Drinks	○	○	○	○
Water	○	○	○	○
Salty Foods	○	○	○	○
Sugary Foods	○	○	○	○
Artificial Sweetener	○	○	○	○

Patient Name_____**Date**_____**Chart #**_____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you are currently experiencing.

A=Ache **P**=Pins & Needles **N**=Numbness
B=Burn **S**=Stabbing **O**=Other



Insurance Information

Do you have extended health benefits? □Yes □No
Name of insurance company_____
Policy #_____Plan#_____ID#_____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Massage Policy

24 hour cancellation notice is required. Failure to do so will result in a full charge for the missed appointment.

Patient's Signature_____Date_____