Community Chiropractic Center

116-11811 Tecumseh Road East
Tecumseh, ON N8N4M7 Tel: (519) 735-7555

O Dr. Todd Small
O Dr. Sarah Dale

Confidential
Patient Health History

Date: _____ Patient No.: _____

Name: _____ **O** Female **O** Male

Address: _____

City: _____ Postal Code: _____

H. Phone: (____) _____ Health Card Number: _____

C. Phone: (____) _____ Family Doctor: _____

Date of Birth: [ ][ ][ ] (year / month / day) Age: _____ Referred By: _____

Employer: _____ Occupation: _____

Work Phone: (____) _____ Ext: _____

Spouse's Name: _____

Names & Ages of children: _____

Email Address: _____

Have you received previous chiropractic care? **O** YES **O** No If Yes:

From who: _____ When: _____

Insurance Information:

We currently bill directly to the following Insurance companies: Photocopy of card required

Green Shield	O Yes		Standard Life	O Yes
Great West Life	O Yes	OR		
Sunlife	O Yes			
Blue Cross	O Yes		Other: _____	

About Your Health

The human body is designed to be healthy. There are many events that occur and habits that we pick up throughout our lifetime that may not allow us to maximize the expression of our optimum health potential. Please take a moment now to fill out these few simple questions so that we might better understand your overall health picture and develop an appreciation of the layers of damage that may exist in your body which are helping to block your body's innate ability to be well and healthy.

Symptoms and ill health

As the years go by and the layers of damage increase, it is common to begin to experience symptoms and random bouts of ill health until we are brought to our present state of health.

Present reason for consulting our office

O Correction and prevention of existing problem?
O Maximizing personal / or family health potential

If you have a specific chief complaint, describe briefly. If not, please go to the next page.

_____

_____

How and when did this problem start?

_____

Is there a previous history?

_____

Does the pain radiate or travel anywhere else? _____

Is the problem…	O Constant	O intermittent	O worse with movement
Is problem worse…	O in the a.m.	O in the p.m.	O no change

Is the condition interfering with…

O sleep	O work	O routine	O other _____

Is the condition getting progressively worse? O Yes O No

Pain is…	O sharp	O dull	O throbbing
O aching	O shooting	O nagging	O other _____

What aggravates your condition / pain? _____

What relieves your condition / pain? _____

If your condition was treated in the past, please describe treatment and results.

_____

_____

_____

Have you had x-rays taken of this area? O Yes O No

Secondary complaints? _____

_____

_____

Have you ever or do you presently suffer from any of the following symptoms?
Please list present treatment and include any medications being taken.

O Headaches	O Ears ring	O Stiff/painful neck	O Nervousness
O Depression	O Tension	O Fatigue	O Sleep problems
O Chest pains	O Heart/lung trouble	O Digestive disorders	O Menstrual problems
O Numbness or pins & needles in arms	O Numbness or pins & needles in legs	O Cold feet/hands	O Arthritis - where?

Is there any other medication / treatment you are receiving? (include birth control pills)

List any surgeries and include when?

What, if any, side effects have you experienced from your medications or surgery?

Do you suffer from or is there a family history of:

	Heart Disease	Stroke	Cancer	Arthritis	Diabetes	Other
Self	O	O	O	O	O	O
Mother's side	O	O	O	O	O	O
Father's side	O	O	O	O	O	O

About your care

Chiropractic treatment provides three types of care. The first is Initial Intensive Care, which corrects the most recent layer of spinal and neurological damage. This care usually reduces or eliminates the symptoms. Next is Reconstructive Care, which corrects the years of damage that occurred when there were a few symptoms. And finally, chiropractic offers a genuine approach to Wellness Care. All of these care options will be explained with your report of findings, then you will be able to begin a course that fits your health goals.

Events and habits

NEONATAL TO ADULT: Many problems have roots in early spinal and/or neurological damage.

Yes	No		Patient's Comments
		1 PREGNANCY: Did your mother…	
O	O	Experience any falls/injuries during pregnancy?	
O	O	Experience distress during delivery?	
O	O	Experience any prolonged illness?	
		2 GROWING YEARS	
O	O	Were you taught how to care for your spine?	
O	O	Any notable falls?	
O	O	Any significant childhood injuries or illnesses?	
O	O	Any childhood surgeries?	
O	O	Any prolonged medications?	
O	O	Mental or physical abuse?	
		3 ADULTHOOD	
O	O	Ever in a motor vehicle accident?	
		If yes, When?	
		Any trauma or symptoms?	
O	O	Any notable falls or injuries as an adult?	
O	O	Any bone fractures / surgery?	
O	O	Hobby or sports injuries?	
O	O	Smoke?	
O	O	Drink Alcohol?	
		O Daily O Weekends O Sporadically	
O	O	Exercise regularly?	
		O Daily O Weekends O Sporadically	
O	O	Proper posture?	
O	O	Eat as healthy as you think you should?	
O	O	Are you or have ever been overweight?	
O	O	Occupational stress?	
O	O	Repetitive lifting / bending?	
O	O	Continuous sitting / standing?	
O	O	Extensive computer work?	
O	O	Physical stress?	
O	O	Mental stress?	
O	O	Other traumas or problems?	
		Sleep posture - O side O back O stomach	