Company logo and address goes in this space
(contact CCAA if you need assistance doing this)

CONFIDENTIAL PATIENT HEALTH RECORD

Date:___________________________

Name: _______________________________________

How would you like to be addressed?❒ First Name ❒ Mrs. ❒ Ms. ❒ Mr. ❒ Other: ______________________________

Address: ____________________________________ City: _________________________ Postal Code:________________

Main Phone:______________________ Birth date: ____/____/___ Age:______ Sex: **M F X**
MM DD YR

Work Phone: ______________________

Occupation / Student: ___________________________________ Hours at work / study per week:______________________

Email:____ How did you hear about our clinic?________________________

Do you have children? ❒ YES ❒ NO Names and ages of children: ____

Previous Chiropractor: ❒ NONE ❒ Doctor's name & approximate date of last visit:________________________________

Name of physician:____

CURRENT HEALTH CONDITION

REASON FOR CONSULTING THIS CLINIC:

- ❒ I have no symptoms and I feel well. I am interested in strategies and care to help me optimize my health.
- ❒ I have a specific problem, and seek to improve function after its relief.
- ❒ Get out of pain.

Is your primary concern related to a motor vehicle accident? ❒ YES ❒ NO If yes, date of accident: _____________________

What is your primary concern? _________________________________ For how long?________________________________

Was the onset ❒ sudden or ❒ gradual ? ____

Can you localize the discomfort, or do you feel some discomfort in locations away from the chief area? ___________________

❒ Worse ❒ Better ❒ Same ❒ Comes and goes ___ If so, what is the frequency?__________________________________

Circle one

How would you characterize the discomfort: dull, ache, sharp, stabbing, cramping, tingling, numbness, burning

How intense is the discomfort? **Least 0 1 2 3 4 5 6 7 8 9 10 most**

Is this condition interfering with your: ❒ Work ❒ Sleep ❒ Daily routine ❒ Fitness/Sports ❒ Hobbies ❒ Other

What activities aggravate your condition? ____

Rate the order of aggravation: ___Sit ____ Stand ______Walk (1-Best; 3-Worst)

What activities relieve it?____

Have you had this or a similar condition in the past? ❒ YES ❒ NO If yes, how frequently? ______________________

Past treatment for this or similar condition:
❒ Chiropractic ❒ Massage Therapy ❒ Physiotherapy ❒ Medication:______________ ❒ Other:___________________

Have you had any previous diagnostic imaging? ❒ X-ray ❒ MRI ❒ CatScan ❒ Ultrasound ❒ EKG ❒ EEG ❒ EMG

Do you have a secondary concern? ____

PAST HEALTH HISTORY

Have you ever been in an auto accident: ❒ Past year ❒ Past 5 years ❒ Over 5 years ❒ Never

Describe:____

Hospitalizations: ____

Accidents / falls / other physical or emotional trauma:____

Date of last physical examination:___________________________________

Would you like your physician to be informed about the services provided for you at this clinic?

❒ Yes ❒ No Address:____

What do you think if wrong? ____

How old do you feel?_______________________ How long has it been since you really felt good? _________________

Habits of Lifestyle:	**Heavy**	**Moderate**	**Light**	**None**	Sleep Posture:
Sleep (hrs/night:__________)	❒	❒	❒	❒	❒ Side ❒ Back ❒ Stomach
Exercise (Type:__________)	❒	❒	❒	❒	
Appetite	❒	❒	❒	❒	Age of mattress: ____________
Caffeine	❒	❒	❒	❒	❒ Soft ❒ Hard ❒ Water
Alcohol	❒	❒	❒	❒	
Tobacco	❒	❒	❒	❒	Thickness of pillows you sleep with under your head?______________
Vitamins/minerals	❒	❒	❒	❒	List:_________________________

Drugs and supplements you currently take:

❒ Blood pressure pills ❒ Insulin ❒ Muscle relaxants ❒ Tranquilizers ❒ Pain killers ❒ Birth control

❒ Vitamins / minerals: ____

❒ Recreational drugs:_______________ ❒ Others:____

Any recent weight change? ❒ 🡅 ❒ 🡇 Reason:____

Do you consider your diet to be good? ❒ Yes ❒ No

Daily approximation: fruits/veggies:______ protein:______ fat:______% starches/baked goods:________________

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD: C – Current ; P – Past

Musculo-skeletal
C P
❒ ❒ Neck pain/stiffness
❒ ❒ Upper back pain/stiffness
❒ ❒ Mid-back pain/stiffness
❒ ❒ Lower back pain/stiffness
❒ ❒ Shoulders; left / right
❒ ❒ Arm pain; left / right
❒ ❒ Lower leg; left / right
❒ ❒ Difficulty chewing
❒ ❒ Clicking jaw
❒ ❒ Sudden weakness
Where?________________
❒ ❒ Walking problems
❒ ❒ General stiffness
❒ ❒ Other:________________

Nervous system
❒ ❒ Nervousness
❒ ❒ Numbness: where?___________
❒ ❒ Paralysis
❒ ❒ Dizziness
❒ ❒ Confusion
❒ ❒ Fainting / drop attacks
❒ ❒ Convulsions / seizures
❒ ❒ Cold/tingling extremities
❒ ❒ Tremors
❒ ❒ Sweats
❒ ❒ Difficulty balancing
❒ ❒ Pins and needles sensation:
Where?________________

General
❒ ❒ Fatigue
❒ ❒ Change in energy ❒↑❒↓
❒ ❒ Chills
❒ ❒ Increased stress
❒ ❒ Allergies: to what?_________
____
❒ ❒ Fever: how long?___________
❒ ❒ Headaches – type
❒ ❒ Forgetfulness
❒ ❒ Poor posture
❒ ❒ Depression: how long?_______

Skin
❒ ❒ Rashes
❒ ❒ Skin conditions – type________
❒ ❒ Bruise easily

Gastro-intestinal
❒ ❒ Poor/excessive appetite
❒ ❒ Excessive thirst
❒ ❒ Nausea
❒ ❒ Vomiting
❒ ❒ Diarrhea
❒ ❒ Constipation

C P
❒ ❒ Hemorrhoids
❒ ❒ Liver problems
❒ ❒ Gall bladder problems
❒ ❒ Ulcers
❒ ❒ Hernia: where?_______
❒ ❒ Unexplained weight change
❒ ❒ Abdominal cramps
❒ ❒ Gas/bloating after meals
❒ ❒ Heartburn
❒ ❒ Black/bloody stool
❒ ❒ Colitis inflammatory bowel
❒ ❒ Difficult digestion

Genito-urinary
❒ ❒ Bladder trouble
❒ ❒ Frequent urination
❒ ❒ Decreased bladder control
❒ ❒ Painful urination
❒ ❒ Discoloured urine / blood in urine

Respiratory & Cardiovascular
❒ ❒ Asthma
❒ ❒ Chest pain
❒ ❒ Difficulty breathing
❒ ❒ Wheezing
❒ ❒ Lung problems / congestion
❒ ❒ Chronic cough
❒ ❒ Spitting blood
❒ ❒ Blood pressure problems
❒ ❒ Irregular heartbeat
❒ ❒ Heart problems
❒ ❒ Varicose veins
❒ ❒ Ankle swelling
❒ ❒ Stroke
❒ ❒ Poor circulation
❒ ❒ Phlebitis

EENT
❒ ❒ Visual problems (nystagmus / diplopia)
❒ ❒ Dental problems
❒ ❒ Sore throat
❒ ❒ Hoarseness
❒ ❒ Difficulty swallowing
❒ ❒ Earaches / discharge
❒ ❒ Ringing in the ears
❒ ❒ Hearing problems
❒ ❒ Nose bleeds

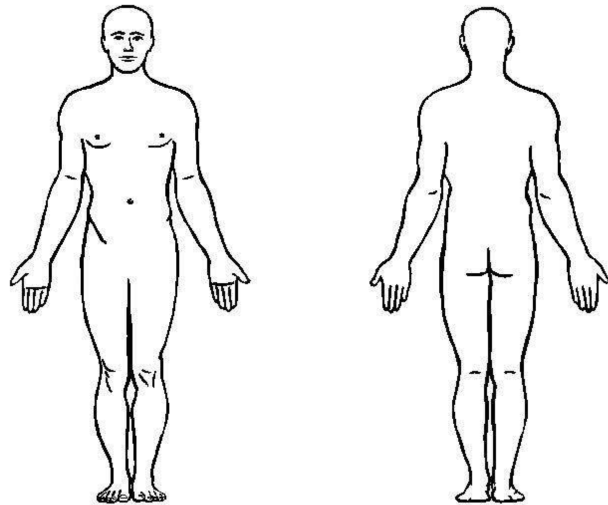
Male/Female
C P
❒ ❒ Prostrate problems
❒ ❒ Sexual dysfunction
❒ ❒ Menstrual irregularities
❒ ❒ Vaginal pain / infection
❒ ❒ Breast pain / lumps
❒ ❒ Miscarriage
❒ ❒ Gynecological surgery
❒ ❒ Menopause
❒ ❒ Caesarian section
❒ ❒ Pregnant; date of last menstruation?

Check any of the following diagnoses you have/had:
C P
❒ ❒ Arthritis other______
❒ ❒ Rheumatoid arthritis
❒ ❒ Osteopenia
❒ ❒ Osteoporosis
❒ ❒ Osteoarthritis
❒ ❒ TB
❒ ❒ Diabetes
❒ ❒ Infection
❒ ❒ Other:____________

C P
❒ ❒ HIV + / -
❒ ❒ Anemia
❒ ❒ Cancer
Type:__________
❒ ❒ Epilepsy
❒ ❒ MS
❒ ❒ Sciatica
❒ ❒ Heart disease
❒ ❒ Disc Herniation

Other therapies that you utilize:
❒ ❒ Acupuncture
❒ ❒ Naturopathic Medicine
❒ ❒ Meditation
❒ ❒ Craniofacial
❒ ❒ Massage
❒ ❒ Shiatsu
❒ ❒ Reflexology
❒ ❒ Reiki

Please outline the areas of discomfort on the diagram:
AAA-aching OOO-pins and needles XXX-burning
///-stabbing *-numbness**



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PLEASE DO NOT WRITE BELOW THIS LINE

ANALYSIS:
DIAGNOSIS:
Patient accepted: ❒ Yes ❒ No ❒ Referred ____