

Confidential Adult and Adolescent (13+) History Form

Please take a few moments to complete this form. Your answers will help us to determine if we can accept your case. If we sincerely believe that your condition will respond more favourably with another health care provider, we will be happy to refer you. If you need help with form, please do not hesitate to ask one of our Chiropractic Health Assistants. THANK YOU.

Personal Information

Date: _____

Name: _____ Gender: M ___ F ___ ___

How do you wish to be addressed in our office? First Name Mr. Ms. Mrs. Miss Dr.

Date of Birth: D ___ M ___ Y ___ Age ___ Marital Status: M S W D Sep

Address: _____ City: _____

Postal Code: _____ Email Address: _____

Primary Phone #: _____ Second Phone #: _____

Emergency Contact – Name & Number: _____

Occupation: _____ Company: _____

Spouse/Partner's Name: _____

Children's Names & Ages: _____

Name of your Medical Doctor/Town: _____

Referrals are our highest form of compliment; please share with us where you heard about our office:

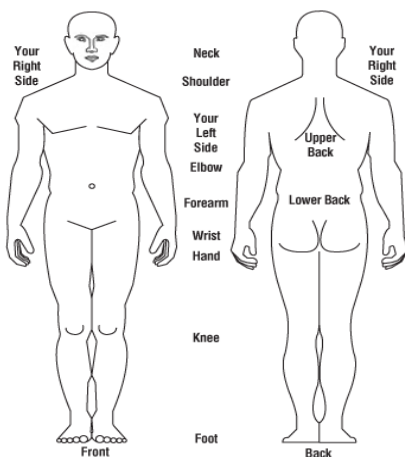
Website Massage Therapist MD Yellow Pages

Current patient - who? _____

Please check the phrase that most represents your reason for care:

Wellness Prevention Feel good Symptom Relief

Current Health Information



Mark the areas where you're having problems.

X Pain
/// Stiffness
O Numbness
~ Improvement in these areas

Why are you seeking chiropractic care? _____

What have you done to help this condition? _____ Was it of benefit? No Yes

Do you have any ideas of factors in your life that may have led to this condition? _____

When did this condition begin? _____ Has this occurred before? No Yes

What aggravates your condition(s)? Sitting Standing Bending Lifting
 Walking Sleeping Weather Change Other _____

What relieves your condition? Cold Heat Massage Medication Rest Other _____

Is it getting? Worse Better Constant Comes & Goes

Character of the pain: Sharp Dull Ache Numb
 Burning Pins & needles Other _____

On a scale of 1-10 please circle the number representing the severity of your pain:
NO PAIN < 1 2 3 4 5 6 7 8 9 10 > SEVERE PAIN

How does this problem affect your life with respect to:

Your ability to work? _____

Your ability to enjoy your family/social time? _____

Your ability to enjoy activities/sports? _____

Compared to 5 years ago, would you say your health is: getting better staying the same getting worse

Check all boxes that pertain to your various stresses:

Emotional Stresses

- Career
- Relationship
- Money
- Children
- Work/Life Balance
- Loss of Loved One

Physical Stresses

- Car Accidents
- Sports Injuries
- Poor Posture
- Excessive Desk Work
- Slips/Falls
- Birth Trauma

Chemical Stresses

- Smoking
- Processed Food
- Medications
- Antibiotics
- Sugar/Artificial Sweeteners
- Work with Chemicals

Medications you currently take: Painkillers Muscle Relaxants Blood Pressure Heart
 Insulin For Indigestion For Depression For Anxiety
 For Asthma For Allergies HRT Birth Control Pill
 Over the counter drugs: _____

Natural supplements you currently take: Multivitamin B-Complex Vitamin
 Vitamin C Calcium
 Omega 3 / 6 / 9 Prenatal Vitamin
 Folic Acid Glucosamine
 Homeopathic Remedies Naturopathic Remedies
 Other _____

Patient Name: _____

What is your personal satisfaction with your diet?

- Highly Satisfied Satisfied Dissatisfied Highly Dissatisfied

Food and diet goals: _____

Do you have a regular exercise program? No Yes Type and how often? _____

Health History

Please check off any hospitalizations or surgical operations and state year:

- Appendectomy Gall Bladder Hernia C-section
 Hysterectomy Back Surgery Broken Bones _____
 Other hospitalizations/Surgeries _____

Concussion/ Knocked Unconscious _____

Do you suffer or have you been diagnosed from any other health conditions?

- Diabetes Heart Condition Hypertension Cancer Respiratory Condition
 Digestive Condition Osteoporosis Other _____

The following is a list of conditions which may seem unrelated to your current complaint. However, we would like to assess your full health picture, and some of these conditions can also affect or be affected by your overall course of care. Please check off ALL of the following you have ever had:

- | | | |
|--|---|---|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Neck/Arm/Shoulder Pain | <input type="checkbox"/> Joint Pain/Stiffness |
| <input type="checkbox"/> Gas/Bloating/Heart Burn | <input type="checkbox"/> Colitis/Irritable Bowel Syndrome | <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Nervous/Stress | <input type="checkbox"/> Difficult Chewing/Clicking Jaw | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Confusion/Forgetful | <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cold/Tingling/Numbness | <input type="checkbox"/> Chest Pain/Shortness of Breath | <input type="checkbox"/> Blood Pressure |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Lung Problems/Congestion | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Ear Aches/Sore Throat | <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Liver/Gall Bladder Problems | <input type="checkbox"/> Abdominal Cramps |
| <input type="checkbox"/> Breast Pain/Lumps | <input type="checkbox"/> Menstrual Irregularity/Cramping | <input type="checkbox"/> Prostate |

Pregnancy: Yes No

Previous Chiropractic Care

- No Yes

Name of Previous Chiropractor & City: _____

Approximate Date of Last Visit: _____

Have you had any x-rays taken in the past 5 years? No Yes Of what area(s)? _____

Patient Name: _____

Family Health History

Does any member of your family suffer from the same condition as you have now? No Yes

Whom? _____

Do you have a family history of any of the following conditions?

- Heart Disease Arthritis Osteoporosis Cancer Diabetes
 Hypertension Stroke Obesity Other _____

Have your children ever had a spinal check-up? No Yes

Doctor's name and when: _____

Informed Consent to Examination

By signing below, you are agreeing to have an examination by Dr. Wood or Dr. Clark at the Clinton Chiropractic & Wellness Centre. The purpose of this examination is to determine the cause of any health problems that you may be experiencing. The examination also allows the doctor named above to determine what the best course of treatment would be in your individual case. The examination may include but not be limited to postural assessment, range of motion testing of various areas of your spine and extremities, various orthopedic and neurological test, and palpation of your joints and muscles using our hands. The chiropractic examination is a "hands-on" approach so that we can best assess your health. The examination may also include a computerized surface EMG analysis.

Patient Name Patient Signature Date Witness

Below are a few office policies and procedures. Please read and initial:

- ___ I agree to Dr. Wood or Dr. Clark discussing with other health practitioners at the Clinton Chiropractic & Wellness Centre health concerns related to my chief complaint.
- ___ I agree to Dr. Wood or Dr. Clark discussing with my medical doctor my health concerns related to my chief complaint.
- ___ I agree to Dr. Wood or Dr. Clark releasing proof of attendance and payment information to 3rd party benefit and insurance companies.
- I agree to have my email address used for:
_____ appointment reminders _____ office updates & newsletters
- ___ I agree that I'm fully responsible for the payment of my account when services are rendered.
- Adults \$42.00 Students (16 & over) \$35.00 Children \$30.00
- ___ We request a notice of 24 hours for any cancelled appointments. A fee of \$25.00 will be applied to your account for missed appointments.

Patient Name: _____