VICTORIA FAMILY CHIROPRACTIC

# Health History

Date ______________

**Name** ________________________________ **Email** ________________________

**Address** ________________________ **City/Prov** ____________ **Postal** ____________

**Home Phone** ______________ **Cell Phone** ____________________ **Work Phone** ____________

**Birthdate (M/D/Y)** ____________ **Care Card #** ____________________ **Occupation** ____________

**Do you have Extended Health Care?** □ Yes □ No **Spouse's Name** ________________________

**Children Names and Ages** ________________________________________

**Is today's visit a result of a: Motor vehicle accident?** □ Yes □ No **or a workplace accident** □ Yes □ No

**Who referred you to our office?** ____________________ **Height/Weight:** ______________

**Past Chiropractic care? If yes, for what and when?** ________________________________

**List your chief complaints in order of severity:**

**1.** ________________________________________ **For how long?** ____________

**2.** ________________________________________ **For how long?** ____________

**3.** ________________________________________ **For how long?** ____________

**Rate the pain of your complaints on a scale from 0 - 10. (0 = No pain, 10 = Severe Pain): 1.**_____**2.**_____**3.**_____

**Name of medical doctor** ________________________________________

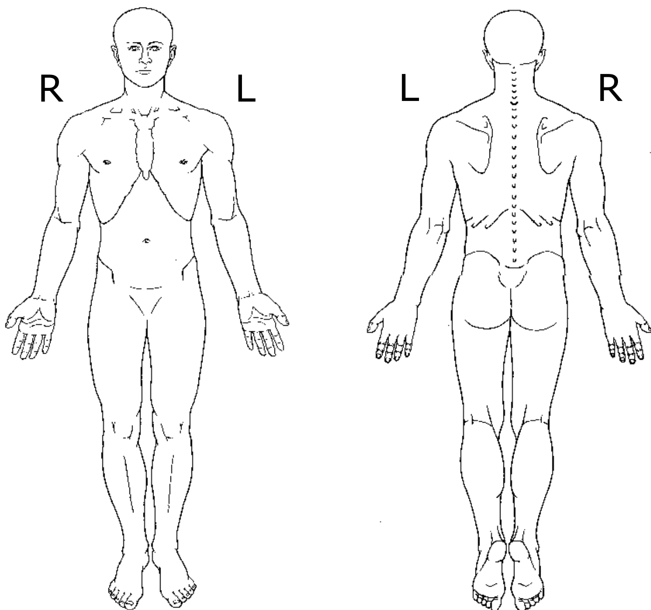
**Are you currently under medical care?** □ Yes □ No **If yes why?** ________________________

**List other doctors or health practitioners you have consulted for this condition** ____________

________________________________________________________________

**Mark the affected area/s on your body**

Describe whether the pain is Burning, Stabbing, Shooting, Dull Ache, Numbness or Pins and Needles




Current Medications________________________________

________________________________________

Current Supplements________________________________

________________________________________

What relieves your symptoms?________________________

________________________________________

What aggravates your symptoms?______________________

________________________________________

What may have caused your problem/s?________________

________________________________________

**Please CHECK anything that applies to you now, or CIRCLE anything that applied in the past.**

## GENERAL:

- ☐ Cancer
- ☐ Unexplained weight change
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Diabetes

☐ Other________________________________________

## NECK:

- ☐ Neck pain
- ☐ Stiff neck and shoulders
- ☐ Numbness or tingling in: shoulders, arms or hands
- ☐ Autism/Learning Disabilities
- ☐ Poor Immune/Autoimmune
- ☐ Headaches
- ☐ Dizziness or balance problems
- ☐ Visual problems
- ☐ Weakness in grip
- ☐ Anxiety/Depression
- ☐ Allergies
- ☐ Jaw problems
- ☐ Sinus problems
- ☐ Low energy or fatigue
- ☐ Thyroid problems
- ☐ High blood pressure
- ☐ Asthma

☐ Other________________________________________

## MID-BACK:

- ☐ Mid-back pain
- ☐ Heart problems
- ☐ Stomach problems
- ☐ Gallbladder/Liver
- ☐ Rib problems
- ☐ Difficulty or pain with breathing
- ☐ Indigestion or heartburn
- ☐ Bloating
- ☐ Lung problems
- ☐ Re-current lung infections
- ☐ Asthma

☐ Other________________________________________

## LOW-BACK:

- ☐ Low-back pain
- ☐ Stiff low-back
- ☐ Numbness or tingling in: buttocks, legs or feet
- ☐ Infertility
- ☐ Sciatica
- ☐ Muscle cramps in legs or feet
- ☐ Weakness in back or legs
- ☐ Constipation or diarrhea
- ☐ Foot problems
- ☐ Painful or irregular menstrual cycle
- ☐ Sexual dysfunction
- ☐ Frequent or difficult urination
- ☐ Prostate

☐ Other________________________________________

**Comments:**________________________________________

Signature ______________________________ Date ______________