thrive chiropractic

A New Healthcare Experience

# NEW PATIENT HEALTH HISTORY

In order to give you the best care possible, please complete this health history as thoroughly as possible. All information is strictly confidential. The doctor will review your history, and with your consent, complete an examination to determine how Chiropractic care may help you.

**Today's Date: _____**

*Office use only:*
☐ AMI ☐ DRI ☐ EXP ☐ ANA ☐ NA

## Patient Data

Full Name: _____ Name of Preference: _____Sex: ☐ M ☐ F
Address: _____ City: _____ Prov:____ Postal Code: _____
Telephone: (Home)_____ (Cell)_____
Birth date: _____ (M/D/Yr) Age: _____
Occupation: _____ Employer: _____

E-mail: _____ ☐ (Do not send periodic info about holiday hours or special events)
Marital Status: _____ Name of Spouse (if applicable): _____
Ages of Children (if applicable): _____

Have you been to a Chiropractor before? ☐ Yes ☐ No
If yes: Which office:_____ When: _____
How did you find out about our office? _____
If you were referred by someone, whom can we thank for referring you? _____
Manitoba Health Number (6 digit): _____ (9 digit): _____

## About Your Health

The human body is designed to be healthy. There are many events that occur and habits we develop throughout our lifetime that affect how well our bodies are able to adapt and heal. This, in turn, affects how truly healthy we are, even without any signs or symptoms.

Rate your **current** health:

| Poor Health | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Optimal Health |
|---|---|---|---|---|---|---|---|---|---|---|---|

What is your health **goa**l?:

| Poor Health | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Optimal Health |
|---|---|---|---|---|---|---|---|---|---|---|---|

Main **goal** in consulting our office:

- ☐ Corrective Care (Pain relief + restoration of spine and joint health)
- ☐ Maintenance/Wellness Care (Corrective Care + ongoing preventative care to help you live your best and prevent reoccurrence)
- ☐ Pain relief only (Not interested in corrective or wellness care)

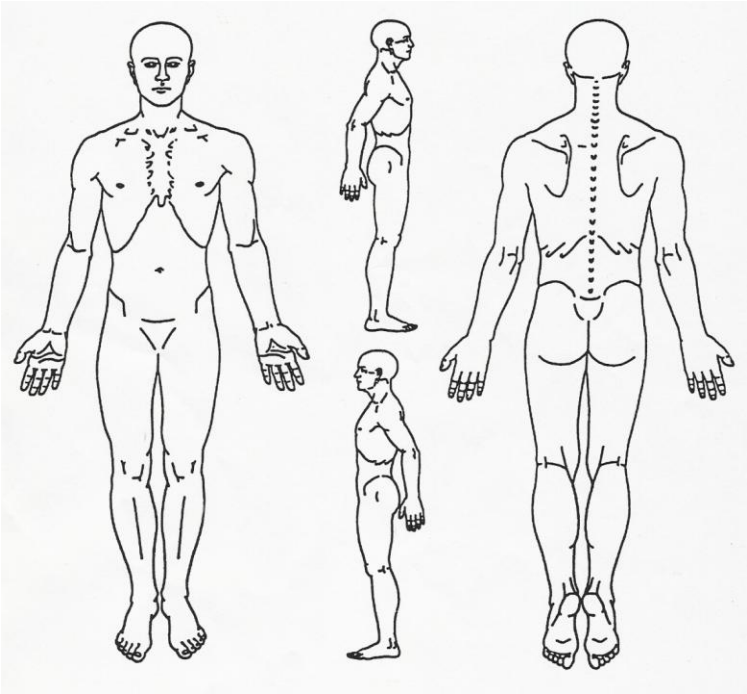
Main reason for consulting our office: Area(s) of complaint:_____
_____

Is this a Worker's Compensation Case? ☐ Yes ☐ No
If yes, date of injury? _____ Type of injury? _____Claim #_____
Name and phone number of *adjuster*? _____

Did your complaint(s) arise from a *Motor Vehicle Accident (MPI)*? ☐ Yes ☐ No
If yes, date of injury? _____ Collision type (i.e. rear-ended) _____Claim #_____
Name and phone number of *adjuster*? _____

Please **circle your area of complaint(s)** on diagram and indicate the **type of pain/discomfort** (A=*Achy, D=Dull, S=Sharp/Stabbing, B=Burning, N=Numbness, P=Pins and Needles, or Other*:_____) next to the area.

Please indicate **current level** of pain **next to each area:** **i.e. ___/10** (10 is the worst pain imaginable)



If complaint is due to an action or event, please explain:

_____

_____

How long have you been living this way? ____ Days, ____ Weeks, ____ Months, or ____Years

Did your complaint(s) come on: ☐ Suddenly ☐ Gradually

Is the complaint(s) getting: ☐ Better ☐ Same ☐ Worse

Is the condition worse in the: ☐ AM ☐ PM ☐ No change

Is the complaint: ☐ Constant ☐ Intermittent ☐ Worse with movement

This condition interferes with my: ☐ Sleep ☐ Work ☐ Family Life ☐ Exercise ☐ Other _____

What aggravates your condition/pain?

_____

What (if anything) relieves your condition/pain? Have you undergone or are you currently receiving treatment?

_____

_____

Have you had any of the following in the last two years? ☐ X-rays ☐ CT Scan ☐ MRI ☐ Bone Scan

☐ Bone Density test If yes, when and which area(s) of body? _____

## Other Symptoms and Conditions

Have you ever had, or do you presently have any of the following? Please note for how long and any associated medications.

| | | | |
|---|---|---|---|
| ☐ Headaches _____ | ☐ Neck pain/stiffness _____ | ☐ Back pain/stiffness _____ | ☐ Ringing in ear(s) _____ |
| ☐ Vision changes _____ | ☐ Loss of balance _____ | ☐ Dizziness or fainting _____ | ☐ High Blood Pressure _____ |
| ☐ Chest Pain _____ | ☐ Stroke _____ | ☐ High cholesterol _____ | ☐ Sleep problems _____ |
| ☐ Fatigue _____ | ☐ Asthma _____ | ☐ Allergies _____ | ☐ Sinus problems _____ |
| ☐ Digestive disorder _____ | ☐ Thyroid disorder _____ | ☐ Poor concentration _____ | ☐ Mood swings _____ |
| ☐ Depression/Anxiety _____ | ☐ Auto immune dis. _____ | ☐ MS _____ | ☐ Menopause _____ |
| ☐ Constipation _____ | ☐ Sexual Dysfunction _____ | ☐ Numb/tingling legs _____ | ☐ Numb/ting. hands _____ |
| ☐ Cold hands/feet _____ | ☐ Diabetes _____ | ☐ Osteoporosis _____ | ☐ Skin disorder _____ |
| ☐ Frequent colds _____ | ☐ Arthritis- Where? _____ | ☐ Seizures _____ | ☐ Kidney Disease _____ |
| ☐ Liver Disease _____ | ☐ History of Cancer _____ | ☐ Drug abuse _____ | ☐ Other _____ |

Please list any other medications: (Please include oral contraceptives and over the counter products)

_____

_____

List any surgeries: (Type and date)

_____

_____

Is there a family history of:

| | Heart Disease | Stroke | Cancer | Arthritis | Diabetes | Other |
|---|---|---|---|---|---|---|
| Mother's side | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Father's side | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |

**Vitals**: (Used to complete your *Posture Screen* Assessment):

Height _____ Blood Pressure (if known) ☐ Low ☐ Normal range ☐ High

Weight _____ _____

## Events and Habits

| Childhood and Adolescence | Yes | No | Date and/or pertinent details |
|---|---|---|---|
| Any notable falls? | ☐ | ☐ | _____ |
| Any significant injuries or illnesses? | ☐ | ☐ | _____ |
| Any surgeries or prolonged medications? | ☐ | ☐ | _____ |

| Adulthood | | | |
|---|---|---|---|
| Past motor vehicle accident(s)? | ☐ | ☐ | _____ |
| Slips or Falls? | ☐ | ☐ | _____ |
| Hobby or sports injuries? | ☐ | ☐ | _____ |
| Smoke? | ☐ | ☐ | _____ |
| Drink alcohol? ☐ Daily ☐ Weekends ☐ Occasional | ☐ | ☐ | _____ |
| Exercise regularly? ☐ Daily ☐ Weekends ☐ Occasional | ☐ | ☐ | _____ |
| Eat as healthy as you think you should? | ☐ | ☐ | _____ |
| Healthy weight? | ☐ | ☐ | _____ |
| Poor posture? | ☐ | ☐ | _____ |
| Extended hours at a computer? | ☐ | ☐ | _____ |
| Repetitive strain? | ☐ | ☐ | _____ |
| Occupational stress? | ☐ | ☐ | _____ |
| Mental stress? Where on a scale of 0-10? **__/10** | ☐ | ☐ | _____ |

Sleeping posture

☐ Side ☐ Back ☐ Stomach

Approximate age of bed _____

**Consent for Communication/Release of Information**

I hereby authorize/grant permission to the above-named office to communicate with other health care professionals, insurance providers, and/or **MPI** (if applicable), and/or the **Worker's Compensation Board** (if applicable), with respect to my file or claim.

Signature(Patient or parent/guardian): _____ Date: _____

**Exam and/or X-ray Consent for Men:** I hereby consent to a chiropractic exam and X-ray evaluation (if necessary) to determine the most appropriate treatment plan.

Signature(Patient or parent/guardian): _____ Date: _____

**Exam and/or X-ray Consent for Women:** This is to certify that to the best of my knowledge I am not pregnant. I hereby consent to a chiropractic exam and X-ray evaluation (if necessary) to determine the most appropriate treatment plan. I understand that x-ray may cause harm to an unborn child.

Signature(Patient or parent/guardian): _____ Date: _____