ERINDALE CHIROPRACTIC HEALTH CENTRE

CONFIDENTIAL PATIENT CASE HISTORY

Name_____ **Age**_____ **Date**_____

Address _____ **City** _____**Postal Code**_____

Home Phone _____ **Work Phone** _____ **Cellular** _____ **Birth Date**_____

Work Address _____ **Referred By:**_____

Occupation _____ **Email Address** _____

Is this a ☐ **Worker's Compensation Injury?** ☐ **SGI? Health Card #**_____

Dear Patient:
Your health is our priority. This form will help us more adequately assess your need for care.

Health Information:

Have you had previous chiropractic care? ☐ **Yes** ☐ **No By whom?** _____

When? _____ **For what condition?** _____

Medical Doctor's Name: _____ **Last seen?** _____

List surgical operations and years:
_____

Drugs you now take or have taken in the past year: ☐ **Pain Killers** ☐ **Muscle Relaxants** ☐ **Corticosteriods**
☐ **Anti-Coagulants/Blood Thinners** ☐ **Vitamins/Supplements**

Please list the names and dosages of the drugs/supplements that you are taking: _____

_____

Have you ever been in an auto accident? ☐ **Yes** ☐ **No When?** _____

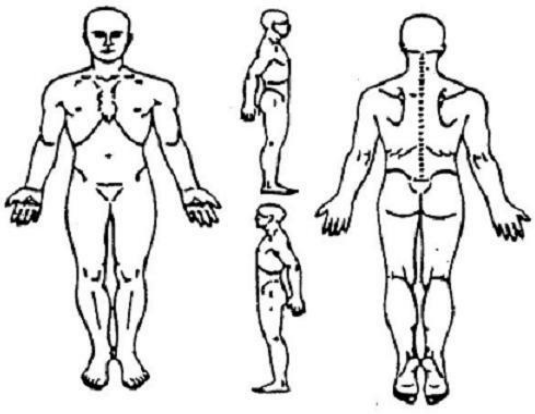
Have you received any care for injuries sustained in your auto accident? ☐ **Physio Therapy** ☐ **Chiropractic** ☐ **MD**
☐ **Massage Therapy** ☐ **Other** _____

Had you ever had x-rays taken of your spine? ☐ **Yes** ☐ **No When** _____

Do you sleep well? ☐ **Yes** ☐ **No What position do you sleep in?** ☐ **Back** ☐ **Stomach** ☐ **Side**

Do you participate in a regular exercise program? ☐ **Yes** ☐ **No Describe** _____

Have you been diagnosed with any of the following: ☐ **Diabetes** ☐ **High Blood Pressure** ☐ **Arthritis** ☐ **Cancer**
☐ **Stroke** ☐ **Transcient Ischemic Attack** ☐ **High Cholesterol**



Primary Complaints (reason for consulting the clinic): _____

_____

Secondary Complaint, if any (describe): _____

_____

Please describe what activities you do on a daily basis (lifting, typing, prolonged sitting/standing) :_____

1. How long have you had your primary complaint? _____

_____

2. How did it start? _____

_____

3. Is it getting worse, better, or staying the same? _____

_____

4. What makes it worse? _____

_____

5. What makes it better? _____

_____

6. What type of previous treatment have you had for this condition: ☐ **Chiropractic** ☐ **Massage Therapy** ☐ **MD** ☐ **Physio Therapy** ☐ **Other** _____

7. Have you had a similar problem before? ☐ **Yes** ☐ **No** **When?** _____

Health Conditions: Please underline any conditions which are presently causing you a problem

RESPIRATORY	NEUROLOGICAL	GASTRINTESTINAL	CARDIOVASCULAR	MUSCLE ANDJOINT
Chronic cough	Visual disturbances	Nausea	High Blood Pressure	Stiff Neck
Chest pain	Co-ordination difficulties	Vomiting	Hardening of arteries	Back Ache
Difficulty breathing	Dizziness	Diarrhea	Swelling of ankles	Neck pain
Asthma	Slurred speech	Constipation		Swollen joints
	Headache			Foot trouble
	Facial numbness			Spinal curvature
	Difficulty swallowing			Faulty posture
				Arthritis

List any other medical concerns not listed: _____

_____

Family Health History	Diabetes	Cancer	Other	List:_____
Father	( )	( )	( )	_____
Mother	( )	( )	( )	_____
Siblings	( )	( )	( )	_____
Children	( )	( )	( )	_____