Erindale
CHIROPRACTIC HEALTH CENTRE

PATIENT HEALTH HISTORY FORM

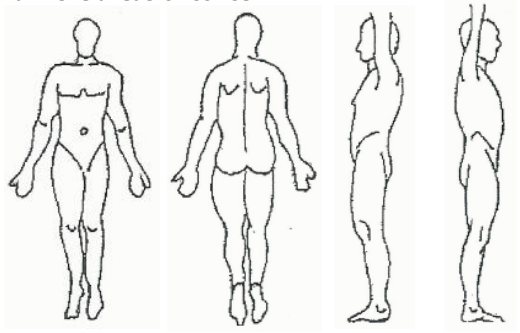
All questions contained in this case history form are strictly confidential.

Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Address:	**City:**	**Postal code:**
Home Phone:	**Mobile phone:**	
Please indicate your preferred contact number: ☐ Home phone ☐ Mobile phone ☐ Other:		
How would you like us to remind you on future appointments? ☐ Email ☐ Text ☐ No reminders, thank you		
If you selected 'EMAIL'**, please leave us your email address:**		
If you selected 'TEXT'**, please indicate who your cell phone provider is:** ☐ SaskTel ☐ Rogers ☐ Bell ☐ Telus ☐ Other: _____		
Marital status & children:	**Occupation:**	
Are you pregnant? ☐ Yes ☐ No ☐ Not applicable	**If YES, when is your due date?**	
Is today's appointment related to any of the following: ☐ SGI ☐ WCB ☐ RCMP/VAC **Claim #**: _____		
Who can we thank for this referral?		

PERSONAL HEALTH HISTORY

Physician's name:
Current medications, vitamins & supplements:
Allergies:
Sports & activities:

Mark the areas of concern:



What is today's reason for treatment?

☐ General maintenance
☐ Relaxation
☐ Injury/pain (**please describe**):

Have you received care from any of the following professionals?
☐ Physiotherapist ☐ Chiropractor ☐ Massage therapist ☐ Acupuncturist ☐ Other:

Which of the following diagnostic tests have you received?
☐ Physician's examination ☐ X-ray ☐ MRI ☐ Ultrasound ☐ Other diagnostic tests: _____

Please list any other health/medical problems that you have (CURRENT and PAST):

☐ Surgery: _____
☐ Fractures/sprains: _____
☐ Serious illnesses: _____
☐ Other: _____

Has anyone in your family had any of the following conditions:

☐ Heart disease ☐ High blood pressure ☐ Diabetes ☐ Cancer ☐ Other diseases Please specify whom: _____

Please check the appropriate symptom if you have ever experienced it:

HEAD AND NECK

☐ Headaches/migraines	☐ Hearing problems	☐ Ringing of ears	Other problems in these areas
☐ Vertigo	☐ Dizziness	☐ Eye problems	(specify): _____
☐ Vision problems	☐ Nose problems	☐ Temporomandibular problems	_____
☐ Sinusitis	☐ Cavities	☐ Jaw or ear pain	_____
☐ Sore throat	☐ Neck pain	☐ Fainting	_____

CHEST, LUNG, HEART, & SKIN

☐ Chest pain	☐ Palpitations	☐ Blood pressure problems	Other problems in these areas
☐ Tachycardia	☐ Fibromyalgia	☐ Excessive or little sweating	(specify): _____
☐ Insomnia	☐ Night sweats	☐ Shortness of breath	_____
☐ Lung problems	☐ Asthma	☐ Restlessness, irritability	_____
☐ Allergies	☐ Skin problems		_____

DIGESTIVE SYSTEM

☐ Bleeding gums	☐ Bruise easily	☐ Heavy legs	Other problems in these areas
☐ Heart burn	☐ Belching	☐ Nausea, vomiting	(specify): _____
☐ Bloating	☐ Abdominal pain	☐ Crohn's disease	_____
☐ Sleepy after meals	☐ Gas, rumbling	☐ Bowel movements after meals	_____
☐ Constipation	☐ Hemorrhoids	☐ Diarrhea	_____
☐ Gaining weight easily	☐ Losing weight easily	☐ Varicosities	_____

LIVER & GALLBLADDER

☐ Liver problems	☐ Sweaty palms	☐ Sweats easily	Other problems in these areas
☐ Irritated easily	☐ Brittle nails	☐ Bitter taste in mouth	(specify): _____
☐ Muscle cramps	☐ Anxiety	☐ Tension headaches	_____
☐ Slow digestion	☐ Restlessness	☐ Stiff joints & muscles	_____

URINARY, ENDOCRINE, & VARIOUS

☐ Kidney stones	☐ Kidney problems	☐ Urinary bladder problems	Other problems in these areas
☐ Prostatitis	☐ Frequent urination	☐ Urinary tract infections	(specify): _____
☐ Varicose veins	☐ Phlebitis	☐ Epilepsy	_____
☐ Feeling cold	☐ Feeling hot	☐ Feeling low energy	_____
☐ Cold hands	☐ Cold feet	☐ Joint pain	_____
☐ Weak or sore knees	☐ Low back pain	☐ Bone problems	_____
☐ Osteoporosis	☐ Osteoarthritis	☐ Rheumatoid arthritis	