Ultimate Family Chiropractic

Your Team Of Wellness Engineers

431 Huronia Road, Unit 6 - Barrie ON, L4N 9B3 | Phone: 705-735-1169 | Fax: 705-252-7833

NEW PATIENT HEALTH HISTORY

Name: ____Date: ___________________ Age: __________

Birth date: (M)_________ (D) _________ (Y) _________ Spouse/Partner Name: ____

Sex: Male ☐ Female ☐ Other ☐ Marital Status: ☐ Single ☐ Married/Common Law ☐ Divorced ☐ Widowed

# of children: __________ their ages: ___________ Address: ____

City: ____ Postal Code: ________________

Email (please print) : ____ Phone: _________________________________

Workplace: ____ Occupation: ____

How did you learn about our clinic? (Patient? Promotion? Print?) ____

Family Doctor's Name: ____________________________________Phone Number: _____________________________________

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system, that have resulted in poor health. Following your exam, Dr. John/Dr. Danielle will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Childhood History

- ☐ Born by Forceps
- ☐ Born by Cesarean
- ☐ Born Breech
- ☐ Stomach sleeper as a child
- ☐ On Antibiotics as a child
- ☐ Used puffers as a child

Childhood Sports: _____________________________________

____

Childhood Surgeries:___________________________________

After Childhood to Present

- ☐ Smoke
- ☐ Drink Alcohol
- ☐ Eat unhealthy foods
- ☐ Little to no exercise
- ☐ Stress (Work, Family, Financial etc)
- ☐ Computer (work or home)
- ☐ Sit at work mostly
- ☐ Stand at work mostly
- ☐ Stomach sleeper
- ☐ Issues with your weight

Adult Sports/Recreation: ____

Date of last sports trauma, and related injuries: ____

Date of last work accident, and related injuries: ____

Date of last slip or fall, and related injuries: ____

Date of last car accident, and related injuries: ____

____

Adult surgeries: ____

Medications you are currently taking: ____

Have you seen a chiropractor in the past? ☐ Y ☐ N If yes, when was your last adjustment? __________________________

How often did you see your chiropractor? ____

What is your present health concern today? ____

How long have you had this condition? ____

What aggravates this condition? ____________________________________ What relieves it? ____________________________

What other doctors have treated you for this condition? ____

How is this condition interfering with your life? ____

What are some other health concerns you have? ____

Name:_______________________________________ Date:_________________________

Please provide details about the pain you are experiencing in any of the following areas, and if it is an ache and/or a sharp pain:
VAS Pain Scale 0-10 (with 10 representing the most severe):

Neck Pain: **0 1 2 3 4 5 6 7 8 9 10**
☐ Constant ☐ Comes and Goes ☐ Right side ☐ Left Side ☐ Both Sides ☐ Ache ☐ Sharp Pain

Upper Back Pain (between the shoulder blades)
0 1 2 3 4 5 6 7 8 9 10
☐ Constant ☐ Comes and Goes ☐ Right side ☐ Left Side ☐ Both Sides ☐ Ache ☐ Sharp Pain

Mid Back Pain: **0 1 2 3 4 5 6 7 8 9 10**
☐ Constant ☐ Comes and Goes ☐ Right side ☐ Left Side ☐ Both Sides ☐ Ache ☐ Sharp Pain

Low Back Pain: **0 1 2 3 4 5 6 7 8 9 10**
☐ Constant ☐ Comes and Goes ☐ Right side ☐ Left Side ☐ Both Sides ☐ Ache ☐ Sharp Pain
Does the low back pain ever radiate down into the : ☐ R Leg ☐ L Leg ☐ Groin ☐ Buttocks

☐ **Shoulder** ☐ **Arm** ☐ **Hand:** ☐ Pain ☐ Numbness/Tingling
Details: ____

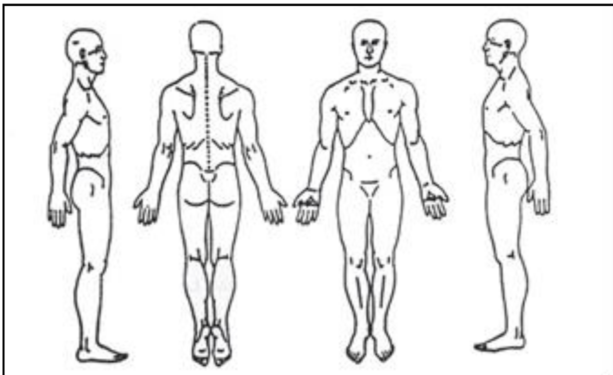
☐ **Hip** ☐ **Leg :** ☐ Pain ☐ Numbness/Tingling
Details:____

☐ **Knee** ☐ **Foot:** ☐ Pain ☐ Numbness/Tingling
Details:____

Symptoms may indicate a long standing spinal condition. Check off symptoms you have now, or have had in the past.

Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Difficulty Breathing
☐	☐	Loss of Concentration	☐	☐	Asthma
☐	☐	Difficulty Sleeping	☐	☐	Frequent colds, Flu
☐	☐	Depression	☐	☐	Ulcers
☐	☐	Irritibility	☐	☐	Digestive problems
☐	☐	Fatigue	☐	☐	Diarrhea
☐	☐	Dizziness	☐	☐	Constipation
☐	☐	Heart Problems	☐	☐	Menstrual Pain
☐	☐	Heartburn	☐	☐	Stroke
☐	☐	Chest Pain	☐	☐	Diabetes
☐	☐	Cancer _________________________	☐	☐	Other ____________________________

Below, please mark an **X** on the areas where you feel pain.



Chiropractor/Exam CA Notes:

____
____
____
____
____
____
____
____
____