8th Street Chiropractic
HEALTH & WELLNESS CLINIC

CONFIDENTIAL PATIENT CASE HISTORY

Name ______________________ **Date** ______________

Address ______________________ **City** ____________ **Province** ____________ **Postal Code** ____________

Home Telephone ______________ **Age** ________ **Birth date** ____________ **Sex: M** ☐ **F** ☐ **Marital Status: M S W D**

Work Address and Telephone ______________________ **Occupation** ______________

Referred by ______________________ **e-mail address** ______________

Is this a ☐ **Worker's Compensation Injury?** ☐ **Motor Vehicle Accident?** **MCIB#** ______________

Have you had previous chiropractic care? ______________

By whom? ______________

When? ______________

For What Condition? ______________

____

Have you ever had spinal x-rays? ☐Yes ☐ No When? ______________

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

Describe: ______________

What vitamins, minerals and/or supplements do you take? ______________

____

Drugs you now take or have taken in the past year:

☐ Pain Killers
☐ Birth Control Pills
☐ Aspirin
☐ Muscle Relaxants
☐ Corticosteriods
☐ Anti-coagulants/blood thinners
☐ Other

Do you smoke? ☐ Yes ☐ No If yes – how much? ______________

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

Describe: ______________

____

____

Date of Last Physical Examination: ______________

Name of Family Medical Doctor: ______________

Approximate Height ____________ Weight ____________

Are you currently pregnant? ☐ Yes ☐ No

On scale of 1-10, describe your stress level (1 = None/ 10 = Extreme):

Occupational ____________ Personal ____________

On a scale of Poor, Good, Excellent describe your:

Diet ________ Exercise ________ Sleep ______ General Health ________

List Surgical Operations and Years: ______________

____

____

____

Have you been diagnosed with any of the following?
☐ Diabetes
☐ High Blood Pressure
☐ Stroke
☐ Transcient Ischemic Attacks
☐ Arthritis
☐ Cancer
☐ High Cholesterol
☐ Other

Please check any symptoms you have experienced during the past 12 months:

Neurological
☐ Visual disturbances
☐ co-ordination difficulties
☐ dizziness
☐ slurred speech
☐ headache
☐ facial numbness

Respiration
☐ chronic cough
☐ chest pain
☐ difficulty breathing
☐ asthma

Cardiovascular
☐ high blood pressure
☐ hardening of arteries
☐ swollen ankles
☐ high cholesterol

Gastrointestinal
☐ nausea
☐ vomiting
☐ diarrhea
☐ indigestion
☐ ulcers
☐ heartburn
☐ constipation

Muscle and Joints
☐ neck pain and/or tightness
☐ mid and upper back pain and/or tightness
☐ low back pain and/or tightness
☐ lower limb joint pain
☐ upper limb joint pain
☐ poor posture

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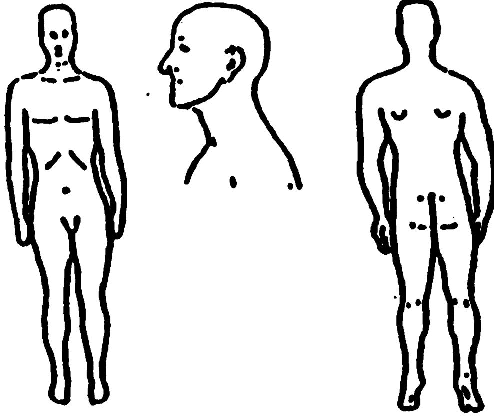
As a full spectrum chiropractic office, we focus on your potential to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. The following information addresses your current health concerns that brought you to our office:

NAME: ____________________ **DATE:** __________

Please mark your areas of concern on the figure below:



1. Reason for consulting the clinic: ____________________
____
____
2. How long have you had your primary complaint? ____________
3. How did it start? ____________________
____
____
4. Is it: ☐ improving ☐ staying the same ☐ getting worse ☐ comes & goes
5. Is it worse in the: ☐ morning ☐ afternoon ☐ evening ☐ night time
6. Yes, it interferes with: ☐ work ☐ sleep ☐ hobbies ☐ leisure activities
7. What makes it worse? (e.g. sitting/standing/lifting) ____________
____
____
8. What makes it better? (e.g. rest/ice/ heat) ____________
____
9. Are you taking medications for the symptoms? ☐ Yes ☐ No
   What? ____________________
10. Please describe what activities you do on a daily basis
    (e.g. lifting, computer work, prolonged standing, sitting): ________
    ____
    ____
11. Previous types of care for your current condition: ☐ Chiropractic ☐ Massage
    ☐ Physical Therapy ☐ Medical Doctor ☐ Specialist ☐ Other