8th Street Chiropractic
HEALTH & WELLNESS CLINIC

CONFIDENTIAL PATIENT CASE HISTORY

Name _____ **Date** _____ mm/dd/yyyy

Address _____ **City** _____ **Province** Select **Postal Code** _____

Home Telephone _____ **Age** _____ **Birth date** _____ mm/dd/yyyy **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? **PHN#** _____

Have you had previous chiropractic care? _____

By whom? _____

When? _____

For What Condition(s)? _____

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

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

How often: _____

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

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

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

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

Describe: _____

Have you had any surgeries? When? _____ What? _____

Have you had past trauma? When? _____ What? _____

Date of Last Physical Examination: _____ mm/dd/yyyy

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 Select Personal Select

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

Diet Select Exercise Select

Do you wake up rested? ☐Yes ☐ No

Do you find it difficult to fall asleep? ☐Yes ☐ No

How many hours a day do you spend on electronics? _____

How many hours a day are you sitting? _____

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
☐ difficulty concentrating

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

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

Muscle and Joints
☐ neck pain
☐ back pain
☐ upper limb pain
☐ lower limb pain

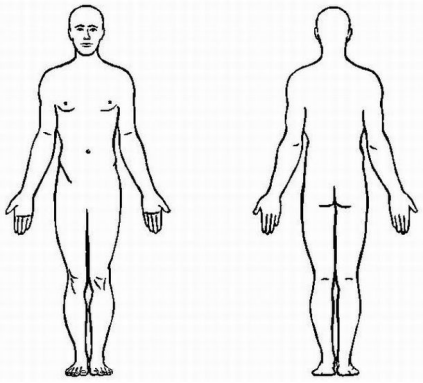
Cardiovascular
☐ high blood pressure
☐ palpitations
☐ swollen ankles
☐ high cholesterol
☐ bruise easily

Do you experience headaches? How often? _____

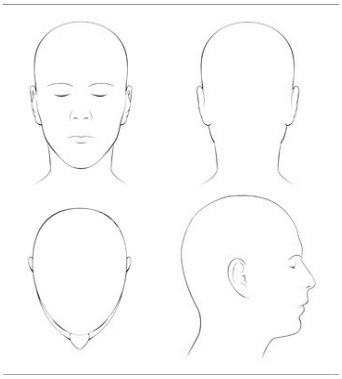
As a full spectrum chiropractic office, we focus on your potential to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. The following information addresses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

NAME: _____ **DATE:** _____ mm/dd/yyyy

Please mark your areas of concern on the figure below:



Do you get headaches? ☐Yes ☐ No
Place and 'X' where you have headaches.



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

12. What would you rate your pain level on a scale of 0 to 10?

    0 being no pain 10 being unbearable pain Select