8th Street Chiropractic
HEALTH & WELLNESS CLINIC

Confidential Patient Information

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

DOB: _____ mm/dd/yyyy **Age:** _____ **HSN:** _____ **Exp:** _____

Address: _____ **City:** _____ **Prov:** Select **Postal Code:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Email Address: _____ **Occupation:** _____

Height: _____ **Weight:** _____ **Marital Status:** M☐ S☐ W☐ D☐

Are you currently pregnant? ☐ **Yes** ☐ **No**
Previous pregnancies? ☐ **Yes** ☐ **No**

Name of Family Doctor: _____

Date of Last Physical Exam: _____

Is this appointment for a: ☐ **Work injury?** ☐ **Motor Vehicle Collision?**

Whom may we thank for referring you? _____

General Health History

Have you been diagnosed with any of the following?

☐ **Diabetes**
☐ **High Blood Pressure**
☐ **Anemia**
☐ **High Cholesterol**
☐ **Stroke**
☐ **Transcient Ischemic Attacks**
☐ **Arthritis**
☐ **Cancer** **Type?** _____
☐ **Other** _____

Have you had any surgery? (Please include all surgery)
Describe:

) _____ **When:** _____
) _____ **When:** _____
) _____ **When:** _____

Have you been involved in any work related, automobile or other significant personal injury?
Describe:

) _____ **When:** _____
) _____ **When:** _____
) _____ **When:** _____

Do you exercise regularly? ☐ **Yes** ☐ **No** **Describe:** _____

How many hours of sleep do you get most nights? _____

Have you had previous chiropractic care? ☐ **Yes** ☐ **No** **When?** _____ **Doctor's Name:** _____

For what condition? _____

8th Street Chiropractic
HEALTH & WELLNESS CLINIC

Patient Name: _____

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past six months:
(prescription and non-prescription):

- ☐ **Corticosteroids**
- ☐ **Anticoagulants/Blood thinners/Aspirin**
- ☐ **Birth Control Pills**
- ☐ **Cholesterol Lowering Drugs**
- ☐ **Pain Killers**
- ☐ **Muscle Relaxants**
- ☐ **Antidepressants**
- ☐ **Other** _____

Please list all nutritional supplements and vitamins you presently take:

- ☐ **Multivitamin**
- ☐ **Vitamin C**
- ☐ **B Vitamins**
- ☐ **Digestive enzymes**
- ☐ **Omega 3 oils**
- ☐ **Coenzyme Q10**
- ☐ **Calcium/Magnesium**
- ☐ **Other** _____

How many hours do you sit each day (including work and home)?
Weekdays _____ **Weekends** _____

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

Gastrointestinal
- ☐ **Indigestion**
- ☐ **Ulcers**
- ☐ **Heartburn**
- ☐ **Constipation**

Respiratory
- ☐ **Chronic cough**
- ☐ **Chest pain**
- ☐ **Difficulty breathing**
- ☐ **Asthma**
- ☐ **Sleep apnea**

Cardiovascular
- ☐ **High blood pressure**
- ☐ **Hardening of arteries**
- ☐ **Swollen Ankles**
- ☐ **High Cholesterol**

Neurological
- ☐ **Visual disturbances**
- ☐ **Coordination difficulties**
- ☐ **Dizziness**
- ☐ **Slurred speech**
- ☐ **Poor Posture**
- ☐ **Balance problems**

Muscle and Joints
- ☐ **Neck pain and/or tightness**
- ☐ **Mid and upper back pain**
- ☐ **Low back pain and/or tightness**
- ☐ **Lower limb joint pain**
- ☐ **Upper limb joint pain**

Have you had spinal X-rays? ☐ **Yes** ☐ **No**
When? _____

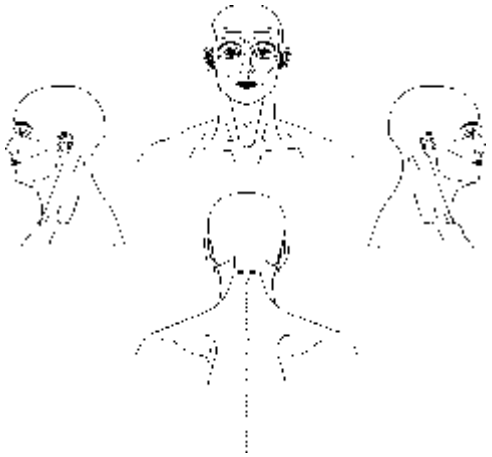
To further evaluate some conditions, X-rays are required.
Do you consent to any necessary radiographic studies?
☐ **Yes** ☐ **No** ☐ **Maybe**

8th Street Chiropractic
HEALTH & WELLNESS CLINIC

Patient Name: _____

Do you experience headaches? ☐ No ☐ Yes

Please mark the area of headache pain on the diagram:



How long have you experienced headaches?
Weeks ____ **Months** ____ **Years** ____

How frequent have the headaches been during the last 6 months?
_____

What time of day do the headaches occur? _____

Has there been any recent increase in severity, frequency or duration of the headaches? ☐ No ☐ Yes
Describe: _____

Do the headaches interfere with:
☐ Work ☐ Leisure activities ☐ Quality of life

What do you think is the cause of the headaches?
_____

_____

_____

Have you received a diagnosis for the headaches? ☐ No ☐ Yes
If yes, what was the diagnosis?
☐ Migraine
☐ Cluster
☐ Tension type
☐ Sinus
☐ Temporal arteritis

Do you take over the counter or prescription medications for the headaches?
Type: _____ **Number per day** ____ **Number per week** ____

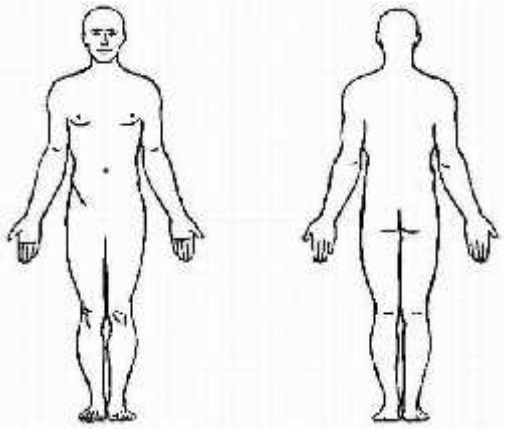
Type: _____ **Number per day** ____ **Number per week** ____

Do the medications help? ☐ Not really ☐ Yes, mild relief ☐ Yes, moderate relief ☐ Yes, total relief

8th Street Chiropractic
HEALTH & WELLNESS CLINIC

Patient Name:

Please mark your areas of concern on the figure below:



Primary reason for consulting the clinic:

How long have you had your primary complaint?

How did it start?

Is it:
☐ Improving **☐ Staying the same**
☐ Getting worse **☐ Comes and goes**

Is it worse in the:
☐ Morning **☐ Afternoon**
☐ Evening **☐ Night**

Does it interfere with:
☐ Work **☐ Sleep** **☐ Hobbies** **☐ Sports/Exercise**
☐ Other (explain)

What makes it worse?

What makes it better?

Are you taking prescription or over the counter medication for the symptoms? ☐ Yes ☐ No
Type:
Number per day **Number per week**
Type:
Number per day **Number per week**

Have you seen any of the following for this condition?
☐ Chiropractor **☐ Medical Doctor**
☐ Massage Therapist **☐ Specialist**
☐ Physical Therapist **☐ Other**

Is there anything else which may help to better understand you or your health challenge which has not been discussed?