NORFOLK CHIROPRACTIC WELLNESS CENTRE

CHIROPRACTIC PATIENT HEALTH HISTORY

Please complete this questionnaire. Your answers will help us determine how Chiropractic can help you.

NAME: ______________________ **INITIAL VISIT DATE:** ______________

Address: ______________________ City ______________ Postal Code ______________

Please check your preferred method(s) of contact

❑ Cell Phone #: ______________

❑ Home Phone #: ______________ ❑ Email - home: ______________

❑ Work Phone #: ______________ ❑ Email - work: ______________

Birthdate *(M/D/Y)* ______________ Sex: M / F Ht: ______ Wt: ______ Family Dr: ______________

Occupation: ______________ Employer: ______________

How did you hear about us? ❑ Y Pgs ❑ Internet ❑ Referral: ______________ ❑ Other: ______________

Have you had Chiropractic care before? ❑ No ❑ Yes Dr. ______________ Last visit: ______________

Have you ever had "Spinal" x-rays taken? ❑ No ❑ Yes Reason: ______________ Date: ______________

Other "Diagnostic Imaging": ❑ MRI ❑ CT ❑ Ultrasound ❑ Other Date: ______________ Location: ______________

Please check off all current or previous conditions:

(Current / Previous)

GENERAL SYMPTOMS
- ❑ ❑ Headaches
- ❑ ❑ Migraines
- ❑ ❑ Fever
- ❑ ❑ Chills
- ❑ ❑ Sweats
- ❑ ❑ Fainting
- ❑ ❑ Dizziness
- ❑ ❑ Seizures
- ❑ ❑ Convulsions
- ❑ ❑ Fatigue
- ❑ ❑ Loss of Sleep
- ❑ ❑ Nervousness
- ❑ ❑ Loss of weight
- ❑ ❑ Numbness or tingling in arms, legs, hands
- ❑ ❑ Allergies
- ❑ ❑ Wheezing

E.E.N.T.
- ❑ ❑ Failing vision
- ❑ ❑ Near sighted
- ❑ ❑ Far sighted
- ❑ ❑ Eye pain
- ❑ ❑ Hearing loss
- ❑ ❑ Earache
- ❑ ❑ Ringing in ears
- ❑ ❑ Nosebleeds
- ❑ ❑ Sore throat
- ❑ ❑ Hoarseness
- ❑ ❑ Asthma
- ❑ ❑ Chronic cough
- ❑ ❑ Frequent colds
- ❑ ❑ Enlarged thyroid
- ❑ ❑ Tonsilitis
- ❑ ❑ Sinus infection
- ❑ ❑ Enlarged glands

SKIN
- ❑ ❑ Itching
- ❑ ❑ Rashes
- ❑ ❑ Bruising easily
- ❑ ❑ Varicose veins
- ❑ ❑ Sensitive skin
- ❑ ❑ Hives

RESPIRATORY
- ❑ ❑ Chronic cough
- ❑ ❑ Spitting up phlegm
- ❑ ❑ Chest pain with breathing
- ❑ ❑ Difficult breathing

CARDIOVASCULAR
- ❑ ❑ Rapid heart beat
- ❑ ❑ Slow heart beat
- ❑ ❑ High blood pressure
- ❑ ❑ Low blood pressure
- ❑ ❑ Chest pain on activity
- ❑ ❑ Previous stroke
- ❑ ❑ Hardening of arteries
- ❑ ❑ Swollen ankles
- ❑ ❑ Poor circulation

MUSCLE & JOINT
- ❑ ❑ Neck ache
- ❑ ❑ Back ache
- ❑ ❑ Swollen joints
- ❑ ❑ Painful tailbone
- ❑ ❑ Foot pain
- ❑ ❑ Shoulder pain
- ❑ ❑ Knee pain
- ❑ ❑ Hernia
- ❑ ❑ Spinal curvature
- ❑ ❑ Faulty posture
- ❑ ❑ Arthritis

GENITOURINARY
- ❑ ❑ Frequent urination
- ❑ ❑ Painful urination
- ❑ ❑ Blood in urine
- ❑ ❑ Kidney infection
- ❑ ❑ Kidney stones
- ❑ ❑ Bed wetting
- ❑ ❑ Bladder incontinence
- ❑ ❑ Prostate trouble

GASTROINTESTINAL
- ❑ ❑ Poor appetite
- ❑ ❑ Difficult digestion
- ❑ ❑ Excessive hunger
- ❑ ❑ Belching
- ❑ ❑ Heartburn
- ❑ ❑ Nausea
- ❑ ❑ Vomiting
- ❑ ❑ Stomach pain
- ❑ ❑ Constipation
- ❑ ❑ Diarrhea
- ❑ ❑ Flatulence
- ❑ ❑ Hemorrhoids
- ❑ ❑ Liver trouble
- ❑ ❑ Gallbladder trouble
- ❑ ❑ Jaundice
- ❑ ❑ Colitis

WOMEN ONLY
- ❑ ❑ Painful menstruation
- ❑ ❑ Excessive flow
- ❑ ❑ Hot flashes
- ❑ ❑ Irregular cycle
- ❑ ❑ Cramps or backache
- ❑ ❑ Congested breast
- ❑ ❑ Lumps in breast
- ❑ Previous pregnancy

Have you ever had any of the following diseases/conditions?

- ❑ Hypertension
- ❑ Heart Disease
- ❑ Lung Disease
- ❑ Cancer
- ❑ Stroke
- ❑ Mumps
- ❑ Measles
- ❑ Rubella
- ❑ Malaria
- ❑ Tuberculosis
- ❑ Epilepsy
- ❑ Diabetes
- ❑ Anemia
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Chicken Pox
- ❑ Shingles
- ❑ Mononucleosis
- ❑ Venereal Disease
- ❑ Alcoholism
- ❑ Diptheria
- ❑ Polio
- ❑ Influenza
- ❑ Scarlet Fever
- ❑ Rheumatic Fever
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Gout
- ❑ Psoriasis
- ❑ Scoliosis
- ❑ Other (specify): ______________

Has anyone in your family had any of the following diseases/conditions?

- ❑ Hypertension
- ❑ Heart Disease
- ❑ Lung Disease
- ❑ Cancer
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Epilepsy
- ❑ Diabetes
- ❑ Multiple Sclerosis
- ❑ Alzheimers Disease
- ❑ Scoliosis
- ❑ Ankylosing Spondylitis
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Rheumatoid Arthritis
- ❑ Gout
- ❑ Psoriasis
- ❑ Scoliosis
- ❑ Low Back Pain
- ❑ Disc Disease
- ❑ Spinal Surgery
- ❑ Migraine Headaches
- ❑ Other (Specify): ______________

Smoker: ❑ No ❑ Yes - How long? ______________ ***Pregnant:*** ❑ No ❑ Yes - How many weeks? ______________

Medications/Supplements you currently take: ______________

Surgeries you have had in the past: ______________