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)*_____ Gender: ☐ Male ☐ Female ☐ Other _____ Pronouns:_____

Occupation:_____ Employer: _____ Family Dr:_____ Ht/Wt:_____

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		*Current/Previous*		*Current/Previous*		*Current/Previous*	
GENERAL SYMPTOMS		☐/☐	Sore throat	☐/☐	Chest pain on activity	**GASTROINTESTINAL**	
☐/☐	Headaches	☐/☐	Hoarseness	☐/☐	Previous stroke	☐/☐	Poor appetite
☐/☐	Migraines	☐/☐	Asthma	☐/☐	Hardening of arteries	☐/☐	Difficult digestion
☐/☐	Fever	☐/☐	Chronic cough	☐/☐	Swollen ankles	☐/☐	Excessive hunger
☐/☐	Chills	☐/☐	Frequent colds	☐/☐	Poor circulation	☐/☐	Belching
☐/☐	Sweats	☐/☐	Enlarged thyroid	**MUSCLE & JOINT**		☐/☐	Heartburn
☐/☐	Fainting	☐/☐	Tonsillitis	☐/☐	Neck ache	☐/☐	Nausea
☐/☐	Dizziness	☐/☐	Sinus infection	☐/☐	Back ache	☐/☐	Vomiting
☐/☐	Seizures	☐/☐	Enlarged glands	☐/☐	Swollen joints	☐/☐	Stomach pain
☐/☐	Convulsions	**SKIN**		☐/☐	Painful tailbone	☐/☐	Constipation
☐/☐	Fatigue	☐/☐	Itching	☐/☐	Foot pain	☐/☐	Diarrhea
☐/☐	Loss of Sleep	☐/☐	Rashes	☐/☐	Shoulder pain	☐/☐	Flatulence
☐/☐	Nervousness	☐/☐	Bruising easily	☐/☐	Knee pain	☐/☐	Hemorrhoids
☐/☐	Loss of Weight	☐/☐	Varicose veins	☐/☐	Hernia	☐/☐	Liver trouble
☐/☐	Numbness or tingling	☐/☐	Sensitive skin	☐/☐	Spinal curvature	☐/☐	Gallbladder trouble
☐/☐	In arms, legs, hands	☐/☐	Hives	☐/☐	Faulty posture	☐/☐	Jaundice
☐/☐	Allergies	**RESPIRATORY**		☐/☐	Arthritis	☐/☐	Colitis
☐/☐	Wheezing	☐/☐	Chronic cough	**GENITOURINARY**		**REPRODUCTIVE HEALTH**	
E.E.N.T.		☐/☐	Spitting up phlegm	☐/☐	Frequent urination	☐/☐	Painful Menstruation
☐/☐	Failing vision	☐/☐	Chest pain with breathing	☐/☐	Painful urination	☐/☐	Excessive flow
☐/☐	Near sighted	☐/☐	Difficult breathing	☐/☐	Blood in urine	☐/☐	Hot flashes
☐/☐	Far sighted	**CARDIOVASCULAR**		☐/☐	Kidney infection	☐/☐	Irregular cycle
☐/☐	Eye pain	☐/☐	Rapid heart beat	☐/☐	Kidney stones	☐/☐	Cramps or backache
☐/☐	Hearing Loss	☐/☐	Slow heart beat	☐/☐	Bed wetting	☐/☐	Congested breast
☐/☐	Earache	☐/☐	High blood pressure	☐/☐	Bladder incontinence	☐/☐	Lumps in breast
☐/☐	Ringing in ears	☐/☐	Low blood pressure	☐/☐	Prostate trouble	/☐	Previous pregnancy
☐/☐	Nosebleeds						

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

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

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

☐ Hypertension	☐ Tuberculosis	☐ Scoliosis	☐ Gout	☐ Spinal Surgery
☐ Heart Disease	☐ Epilepsy	☐ Ankylosing Spondylitis	☐ Psoriasis	☐ Other (Specify):
☐ Lung Disease	☐ Diabetes	☐ Osteoarthritis	☐ Migraine Headaches	
☐ Cancer	☐ Multiple Sclerosis	☐ Osteoporosis	☐ Low Back Pain	_____
☐ Stroke	☐ Alzheimer's Disease	☐ Rheumatoid Arthritis	☐ Disc Disease	_____

Smoker: ☐ No ☐ Yes - How long?_____ ***Pregnant:*** ☐ No ☐ Yes - How many weeks? _____

Medications/Supplements you currently take: _____

Surgeries you have had in the past: _____

NORFOLK CHIROPRACTIC WELLNESS CENTRE

CONFIDENTIAL CASE HISTORY

PATIENT NAME: _____ DATE: _____

*What is your **Primary Complaint?*** _____

*Describe the **Location** of your **symptoms**:* _____

***How long** has this problem bothered you?* _____

***How often** does it bother you?* ☐ Constantly ☐ Daily ☐ Weekly____x /wk ☐ Monthly___x / month

*Does this problem **refer** to other areas?* ☐**Yes** ☐ **No** Where? _____

Has this problem been progressively getting ☐ **better** or ☐ **worse** ☐ **staying the same** *over time?*

*What is the **level of your pain** at its **worst**?* (**0** = No pain - **10** = Worst pain of my life) _____
*What is the **level of your pain** at its **best**?* (**0** = No pain - **10** = Worst pain of my life) _____

*What is the **Character (Quality)** of your pain?* ☐ Dull/ache ☐ Sharp/stabbing ☐ Burning ☐ Shooting
☐ Pinching ☐ Numbness / tingling ☐ Variable ☐ Other _____

*What **aggravates** your condition?* _____
*What **relieves** your condition?* _____

*What **other treatment** have you tried for this condition?*
☐ Rest ☐ Ice/Heat ☐ Stretches ☐ Physiotherapy ☐ Acupuncture ☐ Massage ☐ Other_____

*What **activities** does this **prevent** you from doing?* _____

*Does this problem cause you to experience any **sleep problems**?*
☐ Difficulty falling asleep ☐ Waking during the night ☐ Waking earlier than normal ☐ Waking unrested

*Please list any **other complaints** (health problems) you would **like to get rid of:***

1. _____ **4.** _____
2. _____ **5.** _____
3. _____ **6.** _____

*Is there anything **preventing** you from getting your problem(s) taken care of?* ☐ Yes ☐ No

*Do you have **any Concerns**?* ☐ None ☐ Time ☐ Transportation ☐ Cost ☐ Other _____

*What are your **goals for care**?* ☐ Pain/symptom relief ☐ Improved function ☐ Correction of the "Cause"
☐ Maintenance & Prevention of other problems ☐ Overall Health & Wellness

*Have you ever had any major **falls?*** ☐ Down the stairs ☐ On ice ☐ Off Bikes ☐ From trees
☐ Other _____

*Have you ever had any **Sports injuries?*** ☐ Sprain/Strain ☐ Fracture ☐ Concussion ☐ Dislocation
☐ Other Describe: _____

*What type of **sleep posture** do you have?* ☐ Belly ☐ Side ☐ Back ☐ More than 1 pillow ☐ Futon/Waterbed

*What type of **Physical stress** do you have at home/work?* ☐ Heavy lifting ☐ Repetitive strain
☐ Overhead work ☐ Prolonged sitting/standing ☐ Computer/desk work ☐ Other _____

*Have you ever been involved in any **motor vehicle accidents** (minor or major)**?*** ☐ Yes ☐ No

1. **Date**(year)**:**_____ **Injuries/Treatment**: _____
2. **Date**(year)**:**_____ **Injuries/Treatment:** _____