M & Y Chiropractic Health and Wellness Centre

Confidential Health History Form

Date: ________________________

Last Name: _____________________________________ First Name: ______________________________ M / F

Address: ________________________________ City: __________________ Postal Code: __________________

Phone# (H): _______________________ (W): _______________________ (C): _________________________

D.O.B. ______/______/_______ Email Address: ____
day month year

Occupation: ____ Employer: _____________________________

Marital Status: Single ______ Married ______ Divorced ______ Separated ______ Widowed ______ Other ______

Emergency Contact Name: ________________________________ Relation: _______________________________

Phone#: _______________________________

How were you referred to our clinic? ____
(person's name, phone book, signs, etc…)

	NAME:	ADDRESS:	PHONE #:
Current Chiropractor:			
Current Massage Therapist:			
Current Naturopath:			
Current Medical Doctor:			

* *

Your Current Health Concerns

What is your main reason for coming in today? ____

____

List in order of importance other health concerns that are troubling you:

1) ____ How long? _______________________

2) ____ How long? _______________________

3) ____ How long? _______________________

4) ____ How long? _______________________

What kind of conventional treatment have you received? ____

____

What would you like to accomplish with our treatments? ____

____

How long has it been since you really felt good? ____

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Please list the medications you presently take: ____

____

Please list the vitamins / supplements you presently take: ______________________________________

____

Please list any known allergies: ____

Your Health History

What is the general state of your health? **Excellent**______ **Good**______ **Average**______ **Fair**______ **Poor**______

What is your current level of energy from 1 to 10 (where 10 is the best you have ever felt)? __________

What is your current approximate weight? _______One year ago? _______ Ideal weight? _______ Height? _______

Please list the 5 most significant stressful events in your life:

1)____ Date: ____________________

2)____ Date: ____________________

3)____ Date: ____________________

4)____ Date: ____________________

5)____ Date: ____________________

Are any of these situations continuing to impact your life? **Yes / No** *(If yes, please circle number.)*

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist?_________________________ Have you in the past?____________________When?________________

Have you had any major injuries? If so, what happened and when? ________________________________

____

____

____

Previous surgeries and hospitalizations (include dates): ____________________________________

____

____

____

How stressed are you? (**0** = no stress…….. **10** = nervous breakdown) **0** 1 2 3 4 5 6 7 8 9 **10**

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Please check the following conditions that apply to you. ***O*** – Occasionally ***F*** – Frequently ***C*** – Constantly

GENERAL

O F C

- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Confusion
- ☐ ☐ ☐ Depression
- ☐ ☐ ☐ Difficulty concentrating
- ☐ ☐ ☐ Fatigue
- ☐ ☐ ☐ Fever
- ☐ ☐ ☐ Forgetfulness
- ☐ ☐ ☐ Hay fever
- ☐ ☐ ☐ Headaches/migraines
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Loss of balance
- ☐ ☐ ☐ Loss of weight
- ☐ ☐ ☐ Nervousness
- ☐ ☐ ☐ Painful tailbone
- ☐ ☐ ☐ Poor posture
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Swollen joints
- ☐ ☐ ☐ Tremors

Other: ____________________

EYES, EARS, NOSE & THROAT

- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Ear infections
- ☐ ☐ ☐ Eye pain
- ☐ ☐ ☐ Glasses/contacts
- ☐ ☐ ☐ Loss of taste
- ☐ ☐ ☐ Nosebleeds
- ☐ ☐ ☐ Repetitive colds
- ☐ ☐ ☐ Ringing in ears
- ☐ ☐ ☐ Sinus problems

Other: ____________________

GENITO-URINARY

- ☐ ☐ ☐ Bed-wetting
- ☐ ☐ ☐ Bladder infection
- ☐ ☐ ☐ Blood in urine
- ☐ ☐ ☐ Frequent urination
- ☐ ☐ ☐ Inability to control bladder
- ☐ ☐ ☐ Kidney infection/stones
- ☐ ☐ ☐ Painful/burning urination
- ☐ ☐ ☐ Prostate problems

Other: ____________________

CIRCULATORY/RESPITORY

O F C

- ☐ ☐ ☐ Anemia
- ☐ ☐ ☐ Arrhythmia
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Bronchitis
- ☐ ☐ ☐ Blood clots
- ☐ ☐ ☐ Chest pain
- ☐ ☐ ☐ Chronic cough
- ☐ ☐ ☐ Cold feet/hands
- ☐ ☐ ☐ Cold sweats
- ☐ ☐ ☐ Difficulty breathing
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ High blood pressure
- ☐ ☐ ☐ Low blood pressure
- ☐ ☐ ☐ Night sweats
- ☐ ☐ ☐ Pain over heart/angina
- ☐ ☐ ☐ Palpitations
- ☐ ☐ ☐ Swelling of ankles
- ☐ ☐ ☐ Varicose veins
- ☐ ☐ ☐ Wheezing

Other: ____________________

SKIN

- ☐ ☐ ☐ Acne
- ☐ ☐ ☐ Bruise easily
- ☐ ☐ ☐ Change in mole
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Rashes
- ☐ ☐ ☐ Warts

Other: ____________________

FOR WOMEN ONLY

- ☐ ☐ ☐ Breast tenderness
- ☐ ☐ ☐ Excessive flow
- ☐ ☐ ☐ Fertility concerns
- ☐ ☐ ☐ Hot flashes
- ☐ ☐ ☐ Irregular cycle
- ☐ ☐ ☐ Menopausal symptoms
- ☐ ☐ ☐ Painful menstruation
- ☐ ☐ ☐ PMS
- ☐ ☐ ☐ Vaginal discharge
- ☐ ☐ ☐ Vaginal itching

Other: ____________________

DIGESTIVE

O F C

- ☐ ☐ ☐ Abdominal bloating
- ☐ ☐ ☐ Abdominal pain
- ☐ ☐ ☐ Belching or gas
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Gall bladder trouble
- ☐ ☐ ☐ Heartburn
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomiting blood
- ☐ ☐ ☐ Poor appetite

Other: ____________________

MUSCLE & JOINT

- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot trouble
- ☐ ☐ ☐ Low back pain
- ☐ ☐ ☐ Neck pain/stiffness
- ☐ ☐ ☐ Pain btwn shoulders

Other: ____________________

PAIN OR NUMBNESS IN

- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Elbows
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Hands
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Jaw
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Shoulders

Other: ____________________