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: __________________

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PLEASE CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD:

☐ Abuse			
☐ AIDS/HIV	☐ Diphtheria	☐ Heart Attack	☐ Pneumonia
☐ Alcoholism	☐ Diverticulitis	☐ Hepatitis	☐ Polio
☐ Aneurism	☐ Eating disorder	☐ Herpes/shingles	☐ Rheumatic fever
☐ Appendicitis	☐ Eczema	☐ Influenza	☐ Rubella
☐ Arthritis	☐ Emphysema	☐ Irritable bowel syndrome	☐ Scarlet fever
Type: ______________	☐ Endometriosis	☐ Lupus	☐ Scoliosis
☐ Cancer	☐ Epilepsy	☐ Malaria	☐ Sjogren's
Type: ______________	☐ Fever blisters	☐ Measles	☐ Spinal cord injury
☐ Cataracts	☐ Fibromayalgia	☐ Miscarriage	☐ Stroke
☐ Celiac disease	☐ Glaucoma	☐ Multiple sclerosis	☐ Tuberculosis
☐ Chorea	☐ Goiter	☐ Mumps	☐ Typhoid fever
☐ Cosmetic surgery	☐ Gout	☐ Osteoporosis	☐ Venereal disease
☐ Crohn's disease	☐ Hardening of the arteries	☐ Pacemaker	☐ Vertigo
☐ Diabetes	☐ Hearing impaired	☐ Pleurisy	☐ Whooping cough

Are there any of these from which you feel you have been never well since? ________________________________

DATE OF LAST:	6 mths	6-18	18+	Never
Spinal examination	☐	☐	☐	☐
Physical examination	☐	☐	☐	☐
Blood test	☐	☐	☐	☐
Chest x-ray	☐	☐	☐	☐
Spinal x-ray	☐	☐	☐	☐
Dental x-ray	☐	☐	☐	☐
Urine test	☐	☐	☐	☐

HABITS:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Tea	☐	☐	☐	☐
Laxatives	☐	☐	☐	☐
Hormones	☐	☐	☐	☐

Personal Habits

What do you enjoy most in your life? ____

What are your main interests or hobbies? ____

What do you worry about most in your life? ____

What nurtures you? ____

Do you exercise? **Yes / No** *If yes, what do you do and how often?*______________________________________

____

Do you have a religious or spiritual practice? **Yes / No**

On a scale of 1-10, how would you rate the quality of your sleep (10 being great)__________________

Do you have a problem falling asleep?____ Staying asleep?____ How much do you sleep?_____hours

How many hours do you think you need?_____ Do you wake refreshed?________________

Do you nap or rest horizontally throughout the day? **Yes / No** For how long?____________

How is your body temperature, compared to others? Warmer Cooler Average

Do you enjoy your work? **Yes/No** Do you take vacations? **Yes/No**

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How often do you get colds, flus, sore throats in a year? ____

Family History

	Mother	Father	Sibling	Grandparent		Mother	Father	Sibling	Grandparent
Cancer					Kidney Disease				
Tuberculosis					Diabetes				
Heart Disease					Asthma				
Stroke					Depression				
High Blood Pressure					Other: ____________				

Occupational/Household

Is your home damp or moldy at all? **Yes/No** Do you have a specialized air filtration at home? **Yes/No**

Do you work in an office building? **Yes/No** Do the windows open? **Yes/No**

Do you work in the presence of toxic fumes or chemicals? **Yes / No**

Do any of your hobbies involve toxic materials? **Yes / No**

Are you currently exposed to second hand smoke? **Yes / No**

What do you use for drinking water? *(Circle)* **Tap Water Bottled Water Filtered Water Rev. Osmosis**

Is there anything else you feel I should know about you? ____

____

____

Please list any additional comments regarding your health and well being: ___________________________

____

____

In order to help us to better understand your health care needs and requirements please answer the following:

Committing to changes in my health is ____

____

What happens when you are not being accountable? ____

____

How do you want to be supported in your health care needs? ____

____

Thank you for taking the time to fill in this lengthy questionnaire.

It is a valuable resource in understanding your health.

CONSENT TO TREATMENT

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Naturopathic medicine is a unique approach to improving health and treating illness. Focusing on prevention, and using natural substances and treatments, Naturopathic Doctors support and stimulate the body's ability to heal itself. The methods used in this clinic for assessment include case history taking, physical examination and laboratory testing. Therapeutics include nutrition, homeopathy, botanical (herbal) medicine, physical medicine, hydrotherapy, detoxification techniques, acupuncture, hypnosis, craniosacral therapy and lifestyle counseling.
Each person must sign this document before any treatment will be rendered.
My signature acknowledges that I have been informed and understand that:

(1) I am encouraged to create a comprehensive health care team working towards my best interests and continue to seek medical care from other health care practitioners qualified to practice in Ontario such as a physician, surgeon, dentist, chiropractor, etc., as required.

(2) I understand that Naturopathic Doctors are required by their licensing boards to perform a screening physical examination on each new patient. This will be adhered to unless a full report is sent by the referring practitioner and that report is accepted by the attending practitioner.

(3) I have received a full and complete explanation of the treatments or services that I may receive at this office and hereby authorize and consent to treatment.

(4) I understand that working with a Naturopathic Doctor involves a team-like approach and while I expect my Naturopathic Doctor to provide me with appropriate individualized advice as to how to attain my wellness goals, I also commit to being responsible for my own health. If I am having difficulty following a treatment plan that I have agreed to, I will contact my Naturopathic Doctor so that we can make whatever modifications are necessary for my lifestyle to ensure that I continue to work towards my goal of wellness at whatever pace we decide on together.

(5) I agree to pay my full account at the time of each visit or treatment, including fees for services and costs of supplements, reference materials and laboratory tests. I am aware that these fees are not covered by OHIP. In the event that an invoice is not paid in a timely manner, I understand that 2% per month interest will be added to any outstanding balances.

(6) I am aware that I can purchase the products recommended by my Naturopathic Doctor at the location of my choice. I am under no obligation to purchase products at M&Y Chiropractic Health & Wellness Centre.

(7) I understand that to provide me with Naturopathic goods and services, M&Y Chiropractic Health & Wellness Centre must collect and use some personal information about me as required by law and governing bodies. Any other use of any personal information will require my express written consent.

(8) I understand that payment is due at the requested appointment time. I understand that M&Y Chiropractic Health & Wellness Centre requires a minimum of 24 HOURS NOTICE of any appointment change or cancellation. If I do not give 24 hour notice or fail to appear for my requested appointment time, I agree to pay the full fee for my appointment. I understand that this time is reserved for me. Initials________________

I, ___________________________________, have read, understood and acknowledge the above statements.

Signature of Patient: ____ Date: ___________________________________

Signature of Primary ND: ____ Date: ___________________________________

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OFFICE POLICIES FOR PATIENTS

It is our experience that our patients who follow these simple guidelines obtain the best results and greatest benefits to their health.

UPON ARRIVAL

Please remove your shoes and check in at front desk. Fill out any necessary forms and return them to front desk. One of our health team members will escort or direct you to your adjusting or treatment room.

Chiropractic – Once you are in an adjustment room please empty your pockets (keys, wallet etc.) and remove any earrings and long necklaces. **Please lie face down on the table as this will relax your muscles and take the stress of gravity off your spine thus facilitating a more comfortable adjustment.**

Registered Massage Therapy, Naturopathic Medicine and Alternative Therapies – Once in your treatment room your practitioner will discuss treatments for the session. This may include areas to be treated, your position on the table, benefits/risks, today's goals and a verbal consent will be obtained before the treatment commences. If you want to change or refuse any part of the treatment at any time you have the right to do so. Your practitioner will then leave the room so that you may undress if necessary and re-enter the room once you are ready. You are covered with sheets at all times; only the area being worked on will be uncovered.

After the treatment your practitioner will suggest a treatment schedule to best suit your individual situation. They may also recommend after care exercises or stretching to further enhance your treatments. You may be asked to complete some paperwork between your treatments to allow your practitioner to fully understand the nature of your issues. Those who follow these recommendations notice better and longer lasting results.

YOUR SCHEDULE

Your specific course of care has been designed just for you by your Health Care Provider and your appointment time has been set aside specifically for you. The importance of keeping your appointments and being on time is crucial to help make our office as efficient as possible for the benefit of all our patients. If you do need to reschedule an appointment we require a minimum of 24 hours notice. Any missed appointments or cancellations without adequate notice may result in a fee being charged to you. Due to the healing nature of your treatments, we request that any missed or cancelled sessions be made up at the earliest available time, ideally within 24 hours. Please understand that as a patient you are responsible for any and all charges incurred during the course of your treatment at our wellness centre. When seeing multiple health team members we will do our best to align your appointments together because we value your time as well. If requested, a personal appointment calendar can be supplied to you.

REFERRALS

Once you understand the importance and benefits provided by each of our Health Care Providers, we are confident that you will want everyone in your family checked. The nicest compliment you can give our clinic is to refer us to your family and friends. Please feel free to ask anyone on our health team for any literature you may require.

Welcome to our Health and Wellness Family.

I agree and understand the above policies. Signed____