

Dr Darren Poncelet, B.Sc., D.C.
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

Emergency Contact Name: _____ Phone#: _____

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

Reason for your visit today? _____

What would you like to accomplish with our treatments? _____

How long has it been since you really felt good?

Are you under medical/therapeutic care? yes no For what condition?

Previous Traumas, Operations and Diagnosed Medical Conditions: _____

Medications you presently take: _____

Vitamins / Supplements you presently take: _____

Please list any known allergies: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pregnant? yes no Due Date: _____

Do you sleep well? yes no What position do you sleep in? _____

Regular exercise? yes no Type of exercise / frequency: _____

Do you wear orthotics (custom arch supports)? yes no

Occupation: _____ Activities: _____

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

| | NAME: | ADDRESS: | PHONE #: |
|----------------------------|-------|----------|----------|
| Current Chiropractor: | | | |
| Current Massage Therapist: | | | |
| Current Naturopath: | | | |

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| | | | |
|-------------------------|--|--|--|
| Current Medical Doctor: | | | |
|-------------------------|--|--|--|

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: _____

CIRCULATORY/RESPIRATORY

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: _____

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: _____

**EYES, EARS,
NOSE & THROAT**

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

Other: _____

SKIN

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

Other: _____

PAIN OR NUMBNESS IN

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

Other: _____

GENITO-URINARY

- Bed-wetting
- Bladder infection
- Blood in urine
- Frequent urination
- Inability to control bladder

FOR WOMEN ONLY

- Breast tenderness
- Excessive flow
- Fertility concerns
- Hot flashes
- Irregular cycle
- Menopausal symptoms
- Painful menstruation

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- Kidney infection/stones
- Painful/burning urination
- Prostate problems

Other: _____

- PMS
- Vaginal discharge
- Vaginal itching

Other: _____