CONFIDENTIAL INTAKE / HEALTH HISTORY FORM

Name:_____ Sex: ☐ M ☐ F	**Home Phone**:_____
How would you like to be addressed?_____	**Mother's** Name: _____
Street address:_____	Work Phone:_____Ext:_____
City:_____Prov:_____Postal Code_____	Cell Phone:_____
Birth date: Month: _____ Day: _____ Year: _____ Age: _____	**Father's** Name: _____
Email:_____	Work Phone:_____Ext:_____
	Cell Phone:_____

Insurance: If you have private insurance, please call your company before your first appointment so that you know:

Name of company: _____ Coverage amount: **$** _____ per year. Renewal date: _____

How did you hear about our office?_____

Have you ever been to a chiropractor before? ☐ No ☐ Yes Last Visit:_____

Reason for appointment: ☐ I have no complaints, I am here for a wellness check-up ☐ I have a specific concern

Describe your primary complaint if applicable:_____

When did your symptom begin?_____ **Have you had a previous incident before?** ☐ No ☐ Yes

What do you think caused your symptom?_____

What aggravates your symptom?_____

What relieves your symptom?_____

Have you had previous treatment for this symptom? ☐ No ☐ Yes Please specify? _____

Have you had other tests or imaging ☐ No ☐ Yes Please specify? _____

Does this symptom interfere with your: ☐ work ☐ sleep ☐ personal life ☐ mood ☐ activities ☐ other

Describe:_____

How frequent do you experience your symptom: ☐ Constant ☐ Occassional **Related family history?** ☐ No ☐ Yes

Describe your symptom: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Burning ☐ Aching ☐ Stabbing Other:_____

Rate the intensity of your symptom (circle): 1 2 3 4 5 6 7 8 9 10 (most intense)

Does your symptom radiate or travel to another place in your body? ☐ No ☐ Yes

If yes, describe:_____

Is your symptom due to an accident? ☐ No ☐ Yes **Type of Accident:** ☐ Auto ☐ Work ☐ Other

Are you here for: ☐ Correction of the causes of your health concerns ☐ Temporary patch care

Hunter CHIROPRACTIC Wellness Centre

HEALTH HISTORY

Please check ✓all conditions / illness you have experienced or have been diagnosed with:

Cancer…….. ☐	Difficulty Swallowing…..…. ☐	Stomach Pain……..... ☐	Infertility……..…… ☐
Unexplained weight loss... ☐	Blurry/Double Vision…….... ☐	Bloody Stools/Urine…….. ☐	Diabetes……..…….. ☐
Chest Pain..... ☐	Chronic Cough..... ☐	Constipation/Diarrhea……... ☐	Allergies..... ☐
Prev. Heart Attacks…….. ☐	Difficulty Breathing……... ☐	Bowel Problems……..…..... ☐	Ringing in ears..... ☐
Poor Circulation..... ☐	Thyroid Dysfunction……..... ☐	Loss of bowel/bladder function…. ☐	Depression..... ☐
Previous Stroke..... ☐	Fever/Chills/Sweat…… ☐	Crohn's Disease……..…... ☐	Anxiety ……..……. ☐
High Blood Pressure…..... ☐	Fainting/Convulsions……. ☐	Colitis…… ☐	Tremors..... ☐
Irregular Heart Beat……. ☐	Spitting Blood..... ☐	Painful Urination……..... ☐	**Females Only:** ☐
High Cholesterol……..… ☐	Nausea or Vomiting……... ☐	Waking to Urinate..... ☐	Painful cycles……..…. ☐
Slurred Speech……. ☐	Hernia..... ☐	Arthritis..... ☐	Irregular cycles ..... ☐

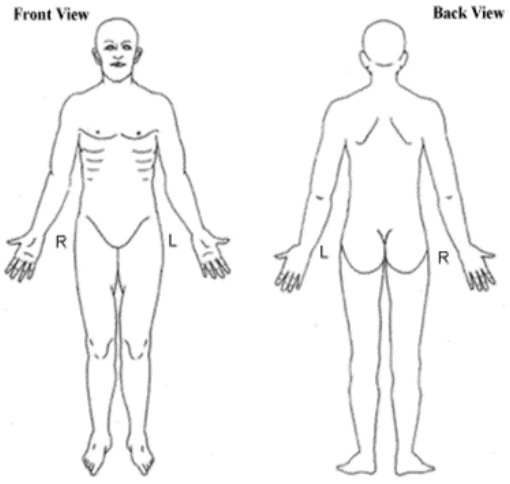
Please list any chronic health diagnoses that you have been given that we should be aware of:

_____

Please check ✓all other conditions you are experiencing:

Headaches..…….... ☐	Elbow pain……..…… ☐	Low energy…… ☐	Frequent colds/flu's…..……... ☐
Neck pain…….…..... ☐	Shoulder pain…….…..... ☐	Irritable / nervousness…… ☐	Heartburn……..……... ☐
Mid back pain..... ☐	Knee pain…… ☐	Skin problems…… ☐	Poor digestion……. ☐
Low back pain……..... ☐	Wrist pain…….…….... ☐	Dizziness…… ☐	Sleeping Difficulty……. ☐
Leg pain/tingling…….. ☐	Ankle/foot pain……..... ☐	Ringing in ears…… ☐	Poor memory…….. ☐
Arm pain/tingling…….. ☐	TMJ pain…… ☐	Poor vision……... ☐	Poor concentration……... ☐

Please indicate with an 'X' the location of your symptoms on the diagram.



Please indicate any other complaints concerning you.

1. _____
2. _____
3. _____
4. _____

List other professionals / doctors consulted for your symptoms:

Type of Professional: _____

Recommendation: _____

Type of Professional: _____

Recommendation: _____

Please list medications you are currently taking <u>and</u> surgeries you have had:

1._____ For? _____ 3._____ For? _____

2._____ For?_____ 4._____ For? _____

Hunter CHIROPRACTIC Wellness Centre

Physical Trauma/Stress Analysis

I) Please describe any accidents, slips/falls, sports injuries, broken bones, childhood traumas, etc.

1. _____

How long ago?_____

2. _____

How long ago?_____

3. _____

How long ago?_____

4. _____

How long ago?_____

5. _____

How long ago?_____

II) Please list any physical/repetitive sports or jobs that your child has engaged in regularly

1. _____ For how many years?_____
2. _____ For how many years?_____
3. _____ For how many years?_____

III) Please list any jobs, school, etc., where your child has sat on a daily basis for > 3 hours per day.

1. _____ For how many years?_____
2. _____ For how many years?_____
3. _____ For how many years?_____

IV) Has your child experienced emotional trauma that has affected them for more than 1 month?
Yes No

V) Does your child experience regular emotional stress from a relationship, school, or other aspect of their life? Yes No

VI) Please describe any other information that may be relevant to your child's health?

_____

_____

Patient's signature: _____ Date: _____

Parent/Legal Guardian's signature: _____ Date: _____