



New Hamburg Wellness Centre

CLIENT HEALTH HISTORY

Dear Client/Patient,

Our primary purpose for collecting personal information about you is to provide you with health services. Information about your health history, your physical condition, function, and your social situation are collected in order to help the doctor assess what your needs are, to advise you of your options, and then to provide the health care you choose to have. The doctor is the only person who will review these forms and your confidentiality will be strictly maintained.

Our ability to draw effective conclusions about your present state of health and how to improve it, depends to a significant extent on your ability to respond thoughtfully and accurately to both these written questionnaires and those questions posed by the doctor during your consultations. There may be questions that may not be relevant/pertaining to your condition. Simply leave these blank for the time being and proceed from there. Thank you for your time in advance and we look forward to working together to achieve your health goals.

TODAY'S DATE: _____

NAME: _____

ADDRESS: _____

POSTAL CODE: _____

PHONE NUMBER: (H) _____ (W) _____ EXT. _____

DATE OF BIRTH: M _____ D _____ Y _____ SEX: M F HEIGHT: _____ WEIGHT: _____

OCCUPATION: _____ EMPLOYER: _____

EMAIL ADDRESS: _____

HEALTH CARD #: _____

VERSION CODE: _____ EXPIRY DATE: _____ (new cards only)

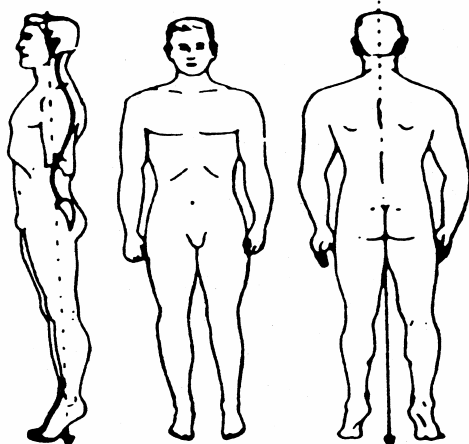
MEDICAL DOCTOR: _____

PAST CHIROPRACTOR & LAST VISIT: _____

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

1. What is your primary reason for seeking care at our centre? _____

On the diagrams below please indicate the area(s) of your chief complaint(s) using the symbols provided



- Numbness = = =
- Pins & needles # # #
- Burning x x x
- Sharp & stabbing // // //
- Dull & aching + + +
- Stiff & tight 2 2 2

2. Are there any secondary reasons for seeking care at our centre? _____

3. Was there an injury, trauma, health significant event which may have contributed? _____

4. How long have you had this condition or these health concerns? _____
5. Any similar or potentially related occurrences/episodes in the past? Y N When? _____
Please explain: _____
6. Please indicate below the severity of any discomfort or any pain you feel now:
- | | | | |
|----------------|---------|-----------|---------|
| | (0) | | (10) |
| Symptom: _____ | Minimal | · · · · · | Extreme |
| Symptom: _____ | Minimal | · · · · · | Extreme |
| Symptom: _____ | Minimal | · · · · · | Extreme |
7. Is your area of primary concern and/or general health:
getting better _____ staying the same _____ getting worse _____. Why do you think so?

8. What activities, factors or positions aggravate your signs and symptoms? _____

9. What if anything have you found to relieve or improve your signs and symptoms? _____

10. Please list all surgical operations you have had, why you had them, the net result and the approximate dates: _____

11. What (if any therapeutic interventions/treatments have you engaged (please circle):
- | | | | |
|---------------|-------------------|------------------------|-------------------|
| Acupuncture | Dentist | Medical Doctor | Podiatry |
| Chinese Herbs | Herbalist | Naturopathic Physician | Reflexology |
| Chiropractic | Homeopath | Nutritionist | Therapeutic Touch |
| Counselling | Massage Therapist | Physiotherapist | Other: _____ |
12. If any of these interventions were of unique value or clearly detrimental, please give details: _____

13. Have you taken any steps personally, beyond the above, to improve your health? Please list and indicate those which led to significant change: _____

14. Please share any significant stressors which you have encountered that could still be impacting your well-being (e.g. change of job, relationship conflict, work environment, loss of loved one, move to different culture, history of abuse, accidents/traumas, addictions, etc.): _____

Check the following conditions you have had/or have:

- | | | | |
|------------------------------------|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Colitis | <input type="checkbox"/> Goiter/Thyroid Disease | <input type="checkbox"/> Poliomyelitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Crohn's | <input type="checkbox"/> High Blood Pressure/Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cystitis | <input type="checkbox"/> Lupus/Rheumatoid Arthritis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Menopause | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whiplash |

Other/Explain: _____

Your family's history of certain conditions:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Autoimmune (Lupus, M.S.) | <input type="checkbox"/> Emotional Disorders | <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Strokes |

Other/Explain: _____

Indicate names of all medications you now use: i.e. Anti-inflammatories celebrex

- | | |
|--|---|
| <input type="checkbox"/> Anti-inflammatories _____ | <input type="checkbox"/> Blood Thinners _____ |
| <input type="checkbox"/> Anti-depressants _____ | <input type="checkbox"/> Heart Medications _____ |
| <input type="checkbox"/> Blood Pressure Meds _____ | <input type="checkbox"/> Aspirin/Tylenol/Advil/OTC-Over The Counter |

Other Medications: _____

Past Medications: _____

Indicate vitamins/minerals/herbs you now use: _____

Do You Now:	Yes	No	Please provide specifics
Wear orthotic devices?			_____ _____
Have insurance coverage for orthotics?			Details and amount of coverage: _____ _____

Our centre is committed to conforming to federal privacy legislation effective January 1, 2004. All information collected is kept strictly confidential, unless the release of this personal information is authorized by yourself, the undersigned, or is required by law. I, the undersigned, believe that all information on this form is true to the best of my knowledge. Completion of this form authorizes the health care practitioner to perform a physical exam for the purpose of formulating a diagnosis and treatment plan.

Signature: _____

Date: _____

PATIENT PAST HISTORY FORM

Name: _____

Date: _____

Please check any conditions or symptoms presently causing you problems.

Please put an to those conditions or symptoms that have been a problem for you in the past.

GENERAL SYMPTOMS:

Allergy
Chills
Convulsions
Dizziness
Fainting
Loss of consciousness
Fever
Headache
Loss of sleep
Nervousness
Depression
Neuralgia
Sweats
Loss of weight
Tremors
Numbness

MUSCLE & JOINT:

Neck stiffness
Neck pain
Low back pain
Mid back pain
Painful tail bone
Foot pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Arthritis
Bursitis
Loss of strength
Pain between shoulders
Sciatica
Swollen joints

GENITOURINARY:

Trouble urinating
Blood in urine
Painful urination
Frequent urination
Loss of control of urination
Kidney infection
Change in smell of urine
Bed wetting
Prostate trouble
Hernia

SKIN:

Rash/itching
Bruise easily
Dryness
Boils
Hives or allergy

RESPIRATORY:

Chest pain
Chronic cough
Difficulty breathing
Spitting blood
Spitting phlegm
Wheezing

CARDIOVASCULAR:

High blood pressure
Pain over heart
Angina
Stroke
Atherosclerosis
Varicose veins
Ankle swelling
Poor circulation
Slow or rapid heart beat

EYES, EARS, NOSE, THROAT:

Blurred vision
Loss of vision
Double vision
Eye pain
Loss of hearing
Ringing/buzzing in ears
Earache
Ear discharge
Asthma
Frequent colds
Sinus infection
Enlarged glands
Enlarged thyroid
Hoarseness
Nosebleeds
Slurring
Sore throat

GASTROINTESTINAL:

Poor appetite
Excessive hunger
Indigestion
Excessive gas
Nausea
Vomiting
Vomiting with blood
Pain in abdomen
Constipation
Diarrhea
Hemorrhoids
Jaundice
Liver trouble
Gall bladder trouble
Colitis/Chron's/IBS
Ulcers
Diabetes

PAIN OR NUMBNESS IN:

Shoulders
Arms
Hands
Hips
Legs
Knees
Ankles
Feet

LIFESTYLE HABITS:

Do you smoke?

Yes No

Amount: _____

Do you drink alcohol?

Yes No

Amount: _____

Do you regularly exercise?

Yes No

Type: _____

Amount/Frequency: _____

FOR WOMEN ONLY:

Cramps
Heavy flow
Light flow
Irregular cycle
Painful cycle
Vaginal discharge
Hot flashes
Sore breasts
Lump in breast

Have you ever been on the birth control pill?

Yes No

Are you currently taking the birth control pill?

Yes No

Are you pregnant?

Yes No

Due date: _____

of past pregnancies: _____

Are you menopausal?

Yes No

Last menstruation: _____