Chestermere Family Chiropractic
C, 124 East Chestermere Drive
Chestermere, AB T1X 1M1
PH: 403-235-3717
FX: 403-235-3716
admin@chestermerefamilychiro.com

General Health History

(Please answer all questions, even if they seem unrelated to your case)

Name: _____ AHC#_____ Date: _____
Address_____Postal Code_____
Phone # (Home) _____ (Cell) _____ (Work) _____
Email address _____
Birthdate (dd/mm/yyyy) _____ Age _____ Sex_____ Wt _____ Ht _____
Children _____ Birthplace _____ Marital Status _____
Emergency Contact (Name & Number) _____
Health Insurance (benefits- Great West Life, Sun Life) _____
Occupation _____ Employer _____

Present complaint_____
When did this condition begin? _____
What do you believe caused this condition? _____
Have you ever had this condition before? _____
Are your symptoms getting ___better ___worse ___staying the same?
___constant ___comes and goes How severe (0 is good, 10 is bad) _____
What makes it better? _____ what makes it worse? _____
Is this work related? _____ Motor Vehicle? _____ Date of accident_____
Please complete the following chart:

Prescription Medication (Include Birth Control)	**Over The Counter Medication** (Tylenol, Advil, etc.)	**Vitamins & Supplements**

Have you seen a chiropractor/RMT before? _____ How long ago? _____
Have you been treated by any other professional? ___physiotherapy ____ massage
Have you been treated for any health condition in the last year? If so, please list any upcoming/recent tests or surgeries _____
Have you had x-rays or tests for this condition? If so, when? _____
___ X-ray ___ultrasound __MRI __other where? _____

How important is your health to you on a scale of 1-10, 10 being most important? _____

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Provide dates of ALL surgeries, fractures, and major illnesses:

_____ _____
_____ _____
_____ _____

List ALL motor vehicle accident dates and other major accidents or falls:

_____ _____
_____ _____
_____ _____

Please "x" and list any of the following devices that you currently wear or are implanted:
☐prosthetic devices _____ ☐hearing aids ☐orthotics
☐implants (pins, wires, artificial joint) ☐pacemaker ☐heal lifts/inserts

Please "**x**" any conditions which are **currently** causing you a problem
Please "**underline**" and conditions which **were** a problem in the past

GENERAL
☐headache
☐migraines
☐dizziness
☐ringing in ears
☐fainting
☐earache
☐sore throat
☐nose bleeds
☐sinus problems
☐asthma
☐enlarged glands
☐unexplained weight loss
☐hyper/hypoglycemia
☐nervousness/anxiety
☐depression/confusion
☐vision problems
☐dental problems
☐hearing problems
☐fever
☐night sweats
☐osteoporosis

ORGANS
☐frequent urination
☐painful urination
☐blood in urine
☐bladder problems
☐kidney stones
☐bed wetting
☐prostate problems
☐sexual dysfunction
☐anemia
☐eating disorders
☐thyroid problems
☐excessive appetite
☐gas/bloating
☐nausea/vomiting
☐constipation/diarrhea
☐Chrons/Colitis/IBS
☐black/bloody stool
☐hemorrhoids
☐liver problems
☐gall bladder
☐rheumatic fever

SKIN
☐eczema
☐skin eruptions
☐varicose veins
☐rashes
☐loss of sensation (pins & needles)
☐sensitivity to lotion
☐contagious conditions

MUSCLE & JOINT
☐neck problems
☐whiplash
☐upper back
☐low back
☐tailbone pain
☐spinal curvature
☐pelvic numbness
☐limb problems
☐walking problems
☐jaw problems
☐arthritis/rheumatoid
☐sore joints/muscles

RESPIRATORY/HEART
☐lung problems
☐chronic cough
☐spitting up blood
☐frequent colds/flu
☐difficult breathing
☐heart problems
☐swollen ankles
☐high/low BP

FEMALES ONLY
☐painful periods/PMS
☐irregular cycle
☐cramps/backache
☐vaginal discharge/ infection
☐lumps/pain in breast
☐menopausal symptoms
☐previous miscarriage
☐unable to get pregnant
☐hot flashes
☐recent abortion/delivery
☐**Are you pregnant**
☐yes ☐no ☐not sure

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Check any of the following you have (or have had):

☐alcoholism
☐HIV
☐hepatitis
☐epilepsy
☐stroke
☐arthritis
☐heart disease/heart attack
☐STD's
☐diabetes
☐cancer
☐allergies
☐nervous system disorder (MS, Parkinson's)
☐other _____

Has anyone in your family had the following?

☐heart disease
☐high blood pressure
☐cancer
☐stroke
☐heart attack
☐arthritis
☐diabetes
☐other
If so, who? _____

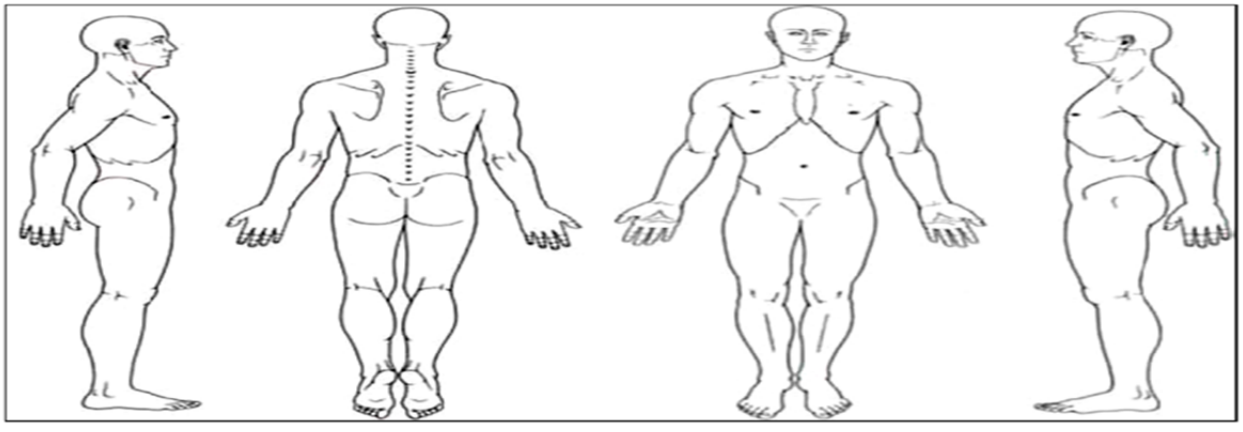
LIFESTYLE

	None	Light	Moderate	Heavy		None	Light	Moderate	Heavy
Exercise	☐	☐	☐	☐	Tobacco	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Alcohol	☐	☐	☐	☐
Coffee/Tea	☐	☐	☐	☐	Junk Food	☐	☐	☐	☐
Pop	☐	☐	☐	☐	Stress	☐	☐	☐	☐

SYMPTOM DIAGRAM

Using the symbols below, please draw on the diagram below to indicate the symptoms you have been experiencing in the locations you are experiencing them.

Numbness = oooooooo	Sharp/Stabbing = ++++++++	Shooting = SSSSSSSSS
Pins and Needles = ********	Ache/Dull Pain = ^^^^^^^^^	Tender = PPPPPPPPPPP



Right Back Front Left