Listro Chiropractic Clinic

CONFIDENTIAL ADULT PATIENT HEALTH RECORD

Date:

111 Redpath Ave Toronto, Ontario 416-481-3378

Personal Information

Name:_____ ____Address:_____
City:_____Province:_____Postal Code:_____
Home phone #:_____Date of Birth:_____ Gender: M___F___
Business/Employer _____Type of work_____
Business phone _____ E-mail address _____
Emergency contact_____ Phone_____ Relationship_____
Whom shall we thank for referring you to our office: _____
Reason for consulting our office today? _____
_____

Your Health Profile

Why This Form is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Please, answer every question.

The Beginning Years (To Age 17)

Research is showing that most of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	Yes	No	Unsure
Did you have any childhood illnesses?	O	O	O
Did you have any serious falls as a child?	O	O	O
Did you play youth sports?	O	O	O
Did you take/use any drugs?	O	O	O
Did you have any surgery?	O	O	O
Have you fallen/jumped from a height over three feet? (ie: crib, bunk bed tree)	O	O	O
Were you involved in any car accidents as a child?	O	O	O

	Yes	No	Unsure
Did you suffer any other traumas? (physical or emotional)	O	O	O
Was there any prolonged use of medicine such as antibiotics or an inhaler?	O	O	O
Were you vaccinated?	O	O	O
As a child, were you under regular chiropractic care?	O	O	O

Were you delivered: Naturally O C-section O
Forceps O Vacuum O Mom induced O Unsure O

Adult Years (Age 18 to present)

	Yes	No
Do/did you smoke?	O	O
Do/did drink alcohol?	O	O
Have you been in any accidents?	O	O
If so was your nerve system checked by a chiropractor afterwards?	O	O
Have you had any surgery?	O	O

For what?_____

	Yes	No
Do/did you participate in extreme sports?	O	O
Do/did you play contact sports?	O	O
If so did you have your spine and nerve system checked regularly by a chiropractor?	O	O

On a scale of 1-10 rate your stress level (1-none, 10-severe)
Occupational stress _____ Personal stress_____

Please check ALL of the following you might have EVER had even if you don't think they are related to the current problem:

- o Stress
- o Loss of sleep
- o Dizziness
- o Fatigue
- o Confusion/ Forgetfulness
- o Imbalance
- o Headaches
- o Migraines
- o Neck/arm/shoulder Pain
- o Leg/knee/foot pain
- o Arthritis
- o Herniated Disc
- o Numbness/tingling
- o Depression
- o Pain between shoulders
- o Pinched nerve
- o Chronic infections
- o Low back/hip pain
- o Low back/hip pain
- o Walking problems
- o Decreased immunity/ frequent colds
- o Asthma/allergies
- o Shortness of breath
- o Heart/vascular Problems
- o Buzzing/ringing In ears
- o Chest pains/ heart disease
- o Miscarriage(s)
- o Menstrual Cramps
- o Frequent nausea
- o Ulcers/ heartburn
- o Diabetes
- o Pain/stiff in mornings
- o Diarrhea/ constipation
- o Thyroid problems
- o Upset stomach
- o Mood swings
- o Liver/gall bladder problems
- o Osteoporosis
- o Bladder trouble/ painful urination
- o Cancer of
- o _____
- o Menstrual irregularity
- o Sexual dysfunction
- o Blood pressure trouble
- o Ankle swelling

List all medications you are taking: _____

For women: Are you pregnant? Yes__ No__ Trying__ Unsure__ Date of last menstrual period:_____

If you have no specific symptoms or complaints, and are here mainly for wellness services, please check (x) Here_____ and skip to "**Family Health Profile".** Those who have symptoms or complaints need to briefly describe the chief area of complaint, including the affect it has had on your life.

_____

_____

If you are experiencing, is it : Sharp O Dull O Comes & Goes O Travels O Constant O

Since the problem started it is: About the Same O Getting better O Getting Worse O

What makes it worse:_____

It Interferes with: Work O Sleep O Walking O Sitting O Hobbies O Leisure O

Names of other Doctors seen for this problem:

Chiropractor_____

Medical Doctor _____

Other_____

Please rate your level of commitment to resolving this/these problem(s) (10 being the highest

1 2 3 4 5 6 7 8 9 10

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have:

Children: _____

Spouse: _____

Mother/Father: _____

Brother(s)/Sister(s): _____

Others: _____

Patient Signature_____Date_____