CHIROPRACTIC PATIENT HEALTH HISTORY

Personal Information

Last Name: _____ First Name: _____ Gender: Male Female Other

Address: _____ City/Prov: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Birth Date (DD/MM/YYYY): _____ **Alberta Health Number:** _____

Height: _____ Weight: _____

Occupation: _____ E-mail address: _____

How did you hear about us? _____

Health History

Purpose of this appointment: _____

_____

List all medications/supplements/vitamins/herbs you currently take: _____

_____

Surgery/operations/hospital stays/serious illnesses/ongoing medical care: _____

_____

_____

_____

Joint replacements - please specify: _____

Major accidents/falls: _____ Broken bones: _____

Please check each of the diseases, conditions, or symptoms that you have currently, or have had in the past. While they may seem unrelated to the purpose of this appointment, they can affect the overall diagnosis, treatment plan, and the possibility of being accepted for chiropractic care.

- ☐ Alzheimer's
- ☐ Aneurysm or Stroke
- ☐ Angina/Chest Pain
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Blood Thinners
- ☐ Bowel or Bladder Issues
- ☐ Bronchitis
- ☐ Bruise Easily
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Cancer
- ☐ Carpal Tunnel Syndrome
- ☐ Chest Pain
- ☐ Chronic cough
- ☐ Circulatory Condition
- ☐ Cold Hands or Feet
- ☐ Cold Intolerance
- ☐ Concussion/Head Trauma
- ☐ Degenerative Disc Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Discoloration of fingers or toes
- ☐ Dizziness
- ☐ Emphysema
- ☐ Excessive Appetite
- ☐ Lowered Immune System
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Fainting
- ☐ Fatigue
- ☐ Fracture
- ☐ Frequent Infections
- ☐ Gastrointestinal Condition
- ☐ HIV/AIDS
- ☐ Headaches
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Surgery
- ☐ Heat Intolerance
- ☐ Hepatitis
- ☐ Herpes (Cold Sores)
- ☐ High Blood Pressure
- ☐ Immunodeficiency
- ☐ Impaired Speech
- ☐ Inflammatory Arthritis
- ☐ Infectious Disease
- ☐ Lightheadedness
- ☐ Loss of Consciousness
- ☐ Low Blood Pressure
- ☐ Lung Conditions
- ☐ Migraines
- ☐ Multiple Sclerosis (MS)
- ☐ Neck Pain
- ☐ Numbness
- ☐ Osteoporosis
- ☐ Pacemaker or similar device
- ☐ Pain that wakes you up at night
- ☐ Parkinson's
- ☐ Poor Circulation
- ☐ Recent unexplained weight gain
- ☐ Recent unexplained weight loss
- ☐ Restless Legs Syndrome
- ☐ Scoliosis
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Spinal Cord Disorder
- ☐ Stroke
- ☐ Swollen Ankles
- ☐ Thyroid Problem
- ☐ TMJ
- ☐ Tremors
- ☐ Varicose Veins
- ☐ Vertigo
- ☐ Warts / Plantars Warts
- ☐ Whiplash

Please list any other health conditions or family history pertaining to your health that is not listed that you feel the doctor needs to be aware of: _____

_____

Allergies: _____

Women (please circle if applicable): Birth control pills Pregnant

Previous chiropractor: _____ Family Doctor: _____

Health History

Do you consume dairy products containing calcium on a regular basis? YES NO

How many alcoholic drinks do you consume per week on average: _____

Do you smoke cigarettes? YES NO How much on average per week? _____

Do you use cannabis? YES NO What form and how often per week? _____

Do you use recreational drugs? YES NO What form and how often per week? _____

Do you consume caffeine? YES NO What form and how much per day? _____

How often you do exercise per week on average? _____

What type of exercise? _____

_____

Do you have annual physicals, screening tests and/or checkups? YES NO

Do you wear arch supports/orthotics? YES NO

Are you interested in learning about custom "made for your feet" orthotics? YES NO

24-Hour Notice for Cancellation of Appointments:

I understand that I will incur and be responsible for a fee of **50% of the appointment price** for same-day cancellations or missed appointments. If the office is closed please leave a voicemail or email. We understand that some circumstances are out of your control, and we will do our best to accommodate you dependent on the situation.

Initial here: _____

Acknowledgment

I understand that I am responsible for all fees incurred for the services provided and agree to ensure full payment of all charges. I further understand that a fee for services rendered will be charged and that I am responsible for this fee whether desirable results are achieved.

Signature	**Date**	**Witness Signature**

Consent to Direct Bill

Insurance Provider: _____

Name of **Primary Insured Member**: _____ DOB of **Primary Insured Member**: _____

Policy/Plan Contract #: _____ Member/Group ID #: _____

I, _____ (Patient), authorize Willow Park Village Chiropractic and Natural Health to collect, use, and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the purposes of:

- ☐ Assessing and submitting claims
- ☐ Auditing and administering the group benefits plan, including the investigation of fraud and/or plan abuse

I agree that a photocopy or electronic version of this authorization shall be valid as the original and may remain in effect for the continued administration of the group benefits plan.

_____
Date

Name of Insured Plan Member (please print)	**Signature of Insured Plan Member**
Name of Witness	Signature of Witness