Chart #___________________
Date___________________

CHIROPRACTIC PATIENT HEALTH HISTORY

Last Name___________________________________ First Name_________________________________ ☐ Male ☐ Female

Address____ City______________________ Province ______

Postal Code________________ Home Phone_____________________________ Cell Phone_________________________

Birth Date (DD/MM/YYYY)_____________________ Alberta Health Care Number_________________________________

May we contact you via e-mail? All contact information is kept confidential and we only send about 1 e-mail/month.

☐ Yes, e-mail address____ ☐ No, thanks.

How did you hear about us?____

Purpose of this appointment____

Is this condition: ☐ Job related ☐ WCB Claim ☐ Auto related ☐ Other

List of therapies tried for this condition____

List all medications you currently take____

Surgery/operations____

Major accidents/falls____ Broken bones__________________________

Hospitalizations____

Previous chiropractor__________________________________ Family doctor_____________________________________

Have you any other health concerns that you have not had satisfactory help with?________________________________

Please check any of the following diseases you have had:

☐ Heart disease ☐ Epilepsy ☐ Pneumonia ☐ Rheumatic fever ☐ Arthritis

☐ Anemia ☐ Pleurisy ☐ Eczema ☐ Goiter ☐ Cancer

Please check your current or past (last 6 months) symptoms:

Neck
- ☐ Headaches
- ☐ Neck pain
- ☐ Arm pain/numbness
- ☐ Joint pain/stiffness
- ☐ Jaw/TMJ pain
- ☐ Sinus troubles
- ☐ Bleeding nose
- ☐ Loss of concentration
- ☐ Ear infections

Mid Back
- ☐ Pain between shoulders
- ☐ Asthma
- ☐ High blood pressure
- ☐ Bronchitis/pneumonia
- ☐ Gall bladder problems
- ☐ Heartburn/indigestion
- ☐ Low energy/chronic fatigue

Low back
- ☐ Constipation
- ☐ Diarrhea
- ☐ Menstrual irregularity
- ☐ Menstrual cramping
- ☐ Increased bladder frequency
- ☐ Prostate problems
- ☐ Leg pain/numbness
- ☐ Cold feet

This clinic operates on fee for service; therefore, payment is required at the end of each visit unless I, the patient, choose one of the alternative payment plans. I understand that I am responsible for the fees I incur at this clinic.

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Patient signature

Updated June 2015