ACTIVE EDGE CHIROPRACTIC

HEALTH HISTORY QUESTIONNAIRE

PERSONAL INFORMATION

Name:_____ ☐ **Female** ☐ **Male** **Alberta Health Care#**_____

Address:_____

City:_____ **Province:**_____ **Postal Code:**_____

Telephone: **Home:**_____ **Work:**_____ **Cell:**_____

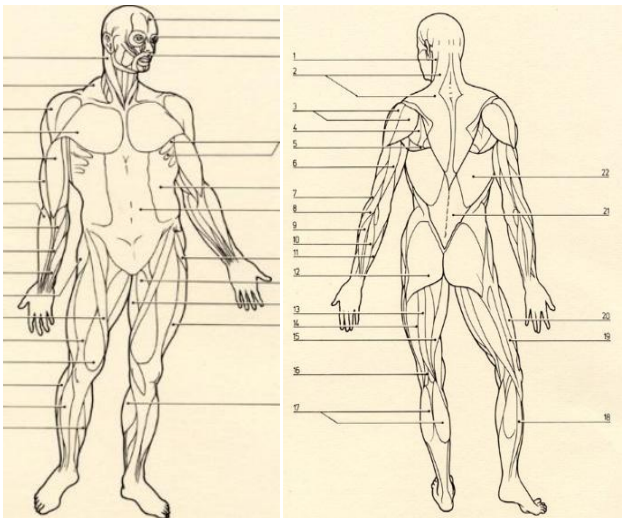
Email:_____ **Birth Date:**_____

Day **Month** **Year**

Occupation:_____ **Who Referred You To Our Clinic?**_____

Using symbols below, mark on body diagram:

X = Pain
O = Numbness
Z = Tingling
/ = Other_____



Using the line scale, indicate the severity of the pain you are experiencing now by circling a number:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN **EXTREME PAIN**

Reason for appointment:_____

_____

When did this begin?_____

Have you ever had similar problems? ☐ **Yes** ☐ **No** _____

How did this occur?_____

Is this condition related to: **Work?** ☐ **Yes** ☐ **No** **Has your employer been notified?** ☐ **Yes** ☐ **No**

Motor Vehicle Accident? ☐ **Yes** ☐ **No** **Date of Injury:**_____

Has the condition ☐ **improved** ☐ **worsened** ☐ **unchanged** **since it began?**

What have you done for this condition?_____

Have you had X-rays, MRI or other tests for this condition? What tests and when?_____

Patient Name:_____ Date:_____

Can you perform your daily home activities? ☐ **Yes** ☐ **Yes, only with help** ☐ **Not at all**

Can you perform your daily work activities? ☐ **All activities** ☐ **Only some** ☐ **Not at all**

Describe your stress level: ☐ **None** ☐ **Mild** ☐ **Moderate** ☐ **High**

Do you exercise? ☐ **Daily** ☐ **Occasionally** ☐ **Not at all**

Please list any previous surgeries, illnesses, injuries (motor vehicle accident):_____

_____

Have you had any fractures or dislocations? ☐ **Yes** ☐ **No** **Body part**_____

Have you had previous chiropractic care? ☐ **Yes** ☐ **No** **Doctor:**_____ **Date:**_____

Family doctor name:_____

List all medications: (prescriptions, vitamins, herbal supports, birth control, aspirin, Advil, Tylenol, Robax, etc.)

_____

What do you hope to achieve from this visit? Check all that apply.

☐ **Pain relief** ☐ **Explanation of your condition** ☐ **Exercises to prevent recurrence**

Are you seeking: ☐ **Lasting corrective care** ☐ **Temporary relief**

Circle the word that best describes the way you feel about your <u>general health</u>:

excellent good acceptable uneasy concerned very concerned

frustrated pained frightened distressed unbearable

Have you recently experienced a major upset in your life? ☐ **Yes** ☐ **No**

Explain:_____

Have you or a family member ever been diagnosed or told you have any of the following? Please check the appropriate box.

High Blood Pressure	☐ Yes	☐ No	☐ Family_____
Hardening of the arteries	☐ Yes	☐ No	☐ Family_____
Diabetes	☐ Yes	☐ No	☐ Family_____
Tuberculosis	☐ Yes	☐ No	☐ Family_____
Cancer, where?	☐ Yes	☐ No	☐ Family_____
Heart or blood disease	☐ Yes	☐ No	☐ Family_____
Stroke	☐ Yes	☐ No	☐ Family_____
Osteoporosis	☐ Yes	☐ No	☐ Family_____
Bone spurs on neck bones	☐ Yes	☐ No	
Whiplash injury (flexion-extension injury, cervical sprain)			☐ Yes ☐ No
Were you ever a smoker?	☐ Yes	☐ No	From_____ to_____
Visual disturbances (blurring, loss, double)			☐ Yes ☐ No
Hearing disturbances (loss, ringing, other noise)			☐ Yes ☐ No
Slurred speech or other speech problems			☐ Yes ☐ No
Difficulty swallowing			☐ Yes ☐ No
Dizziness			☐ Yes ☐ No
Loss of consciousness, even momentary blackouts			☐ Yes ☐ No
Numbness, loss of sensation, strength or weakness in the face, fingers, hands, arms, legs, or any other parts of the body			☐ Yes ☐ No
Sudden collapse without loss of consciousness			☐ Yes ☐ No

Patient Name:_____ Date:_____

SYSTEMS REVIEW

Please *circle* any conditions that are *presently* causing you a problem and underline those that have caused you problems in the past.

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney infection
Nervousness	Difficulty breathing	Prostate trouble
Weight loss	Asthma	Uncontrollable urine flow
Weight gain		
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbances	Rapid beating heart	Poor appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting	High blood pressure	Heartburn
Convulsions	Low blood pressure	Ulcers
Headache	Pain over heart	Nausea
Numbness	Hardening of arteries	Vomiting
Neuralgia (nerve pain)	Swollen ankles	Constipation
Poor coordination	Poor circulation	Diarrhea
Weakness	Palpitations	Blood in stool
	Cold hands or feet	Gallbladder/jaundice
	Varicose veins	Colitis
EENT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**
Eye pain	Neck pain	Painful menstruation
Double vision	Low back pain	Hot flashes
Ringing in ears	Arm pain	Irregular cycle
Deafness	Shoulder pain	Cramps or back pain
Nosebleeds	Leg pain	Vaginal discharge
Trouble swallowing	Knee pain	Nipple discharge
Hoarseness	Foot pain	Lumps in breast
Sinus infection	Pain/numbness down arms or legs	Menopausal symptoms
Nasal drainage	Pain between shoulders	Birth control pills
Enlarged glands	Swollen joints	Miscarriages
	Spinal curvature	Complications with pregnancy
	Arthritis	Pregnant? Y / N Week? Other:
	Fractures	

WRITTEN CONSENT TO NOTIFY FAMILY PHYSICIAN OF CHIROPRACTIC CARE

At Active Edge Chiropractic, we strive to maintain open communication and professional relationships with other health care providers. In order to provide updates to your family doctor regarding your care, we need to obtain written consent from you as our patient. Please fill in the information below so we can inform your doctor about your diagnosis, treatment, and progress at our clinic.

Dated this ____day of_____, 20____.

Family Physician's Name: _____ **Phone:** _____

Patient Signature: _____ **Witness Signature:** _____

Patient Name: _____ **Witness Name:** _____

(please print) **(please print)**

Patient Name:_____ Date:_____

CASE HISTORY (OFFICE USE ONLY)

CHIEF COMPLAINT: **AGE:**

Onset

Frequency

Progression

Quality/Quantity

N/T/W

Radiation

Timing **AM** **PM**

Aggravating

Alleviating

Meds

Trauma

Health Conditions/Surgeries

Family History

Bowel/bladder function changes, unexplained weight loss, fever, chills, night sweats, nausea, vomiting, dizziness, blurred/double vision, dysphagia, nocturnal pain ☐ **Denies all**