HOFFMAN
CHIROPRACTIC & WELLNESS CENTRE
Technology. People. Results.

PERSONAL AND FAMILY HEALTH HISTORY

Today's Date: _____

Name: _____ Is this a WCB/MVA claim? *(Please circle)* WCB MVA N/A

Address: _____ Date of Birth (dd/mm/yyyy): _____ (Age____)

City:_____ Prov.:____ Postal: _____ Sex: ❑ F ❑ M Alberta Health Care #: _____

Phone: (H) _____ (W) _____ Are you or might you be pregnant? ❑ Yes ❑ No

Cell: _____ Occupation: _____ ❑ Not Applicable

Emerg. Contact: _____ (PH) _____ Employer: _____

Email:_____ Marital Status:_____ Spouse's Name: _____

Referred by: _____ Names of children (ages): _____

TRAUMA & INJURIES

Did you ever...		If yes, please explain:
Have any personal injury or accident?	Y / N	_____
Have recurrent childhood illness/sickness?	Y / N	_____
Experience other serious traumas/stress?	Y / N	_____
Have any mental or emotional disorders?	Y / N	_____
Suffer any concussions?	Y / N	_____

Was Your Birth Traumatic?
(Circle if you know…)

Long delivery?..... Y / N
Difficult delivery? ..... Y / N
Forceps/vacuum extractor?.. Y / N
Caesarian section?..... Y / N
Breech/cephalic?..... Y / N
Mother given drugs/
epidural during birth?..... Y / N
Induced labour?..... Y / N

CURRENT HEALTH HABITS

Do you...			
Take Vitamins or Minerals?	Y / N	_____	
Eat healthy foods regularly?	Y / N	Have sleeping problems?	Y / N
Drink 8-10 cups of water daily?	Y / N	Sleeping position: side; stomach; back	_____
Exercise regularly?	Y / N	Have high mental stress?	Y / N
Smoke?	Y / N	Have high physical stress?	Y / N

Have you been to a chiropractor before? Y / N If yes, who have you seen?_____

If yes, for what?_____ When was your last adjustment? _____

FAMILY HEALTH PROFILE – Please mark if you have a family history of:

	Arthritis	*Cancer*	*Diabetes*	*Heart Disease*	*High Blood Pressure*	*Strokes*	*Other*_____
Your father's side	❑	❑	❑	❑	❑	❑	❑ _____
Your mother's side	❑	❑	❑	❑	❑	❑	❑ _____
Your children	❑	❑	❑	❑	❑	❑	❑ _____

MEDICAL INFO: Who is your medical doctor?_____

If you are taking medications, please list them.

Med:_____ For what?_____ For how long? _____
Med:_____ For what?_____ For how long? _____
Med:_____ For what?_____ For how long? _____
Other: _____

What side effects have you experienced from the drugs &/or surgery?

_____
_____
_____

If you have had any surgeries, please list them.

Surgery: _____ For what?_____ Date: _____
Surgery: _____ For what?_____ Date: _____
Surgery: _____ For what?_____ Date: _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

*** If you have no symptoms or complaints and you are here for wellness care, please check here:
❑ *I wish to have Chiropractic Wellness Services*
& skip to the **CURRENT SYMPTOMS** section near the bottom of this form. Otherwise, please continue.

Present Complaint (Reason for your visit today): _____

_____

Pain or problem started how and when? _____

_____

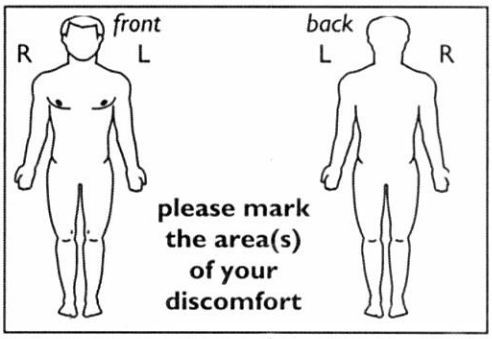
_____

What activities make your condition / pain worse? _____

_____

What activities make your condition / pain better? _____

_____



If you have pain, is it… ❑ sharp ❑ dull ❑ radiating ❑ constant ❑ intermittent ❑ mild ❑ moderate ❑ mod-severe ❑ severe

Since it began, is it… ❑ the same ❑ variable ❑ getting better ❑ getting worse

What time of day is worst? ❑ waking ❑ at work ❑ evening ❑ at night ❑ variable ❑ constant

Does it interfere with… ❑ work ❑ sleep ❑ walking ❑ sitting ❑ exercise ❑ other _____

OTHER TESTS: (please circle)
Have you ever had:
X-rays / CT scan / MRI
of your :
Neck / Back / Hips/pelvis

If yes, how long ago?
<7 years, > 7yrs

Do you remember what the results were? _____

Are there other doctors / treatments that you have tried for this problem? (Please list.)
❑ massage therapist _____ ❑ physiotherapist _____
❑ acupuncturist _____ ❑ medical doctor _____
❑ other _____

For each pain scale below, mark an "X" on the line that describes your level of pain:

CURRENT PAIN INTENSITY
No pain — Moderate pain — Unbearable pain
0 1 2 3 4 5 6 7 8 9 10

AVERAGE PAIN INTENSITY
No pain — Moderate pain — Unbearable pain
0 1 2 3 4 5 6 7 8 9 10

WORST PAIN INTENSITY
No pain — Moderate pain — Unbearable pain
0 1 2 3 4 5 6 7 8 9 10

CURRENT SYMPTOMS (even if they do not seem related to your current condition):

❑ headaches / migraines	❑ dizziness / vertigo	❑ sinus problems / allergies	❑ high blood pressure
❑ neck stiffness / pain	❑ fatigue	❑ shortness of breath	❑ heart problems / stroke
❑ shoulder stiffness / pain	❑ sleeping problems	❑ constipation / diarrhea	❑ cancer
❑ pins & needles in arms	❑ tension / stress	❑ problems urinating	❑ diabetes
❑ numbness in fingers	❑ nervousness / anxiety	❑ cold sweats	❑ recurring infection
❑ back stiffness / pain	❑ irritability / mood swings	❑ hot flashes	❑ loss of smell / taste
❑ pins & needles in legs	❑ depression	❑ menopause	❑ vision changes
❑ numbness in feet / toes	❑ stomach upset	❑ PMS / menstrual cramps	❑ buzzing / ringing in ears
❑ foot problems	❑ heartburn / reflux	❑ infertility / impotence	❑ loss of balance
❑ jaw / TMJ problems	❑ ulcers	❑ cold hands / feet	❑ chest pains

❑ other _____

Please list any known allergies: (food, environmental, drugs, etc.) _____

_____

RESULTS:

As a result of my chiropractic care, I would like to: (Please check all that apply)

❑ ***Feel better quickly*** ❑ ***Live a healthier lifestyle***
❑ ***Have a healthier spine*** ❑ ***Learn about a healthier lifestyle***
❑ ***Have a healthier body by keeping my nerve system healthy***

On a daily basis, we all experience physical, chemical, & emotional stresses that can accumulate & result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, & sometimes not until it is too late!
Hoffman Chiropractic & Wellness Centre we will help to find & treat the cause of these effects.
Chiropractic helps your entire body – for a healthier life & spine!