HOFFMAN CHIROPRACTIC & WELLNESS

PERSONAL AND FAMILY HEALTH HISTORY

Today's Date: _____

Name: _____

Address: _____

City: _____ Prov: ____ Postal: _____

Phone: (H) _____ (W) _____

Cell:_____

Email: _____

Emerg Contact: _____PH_____

Referred by: _____

Occasionally we send surveys, newsletters, updates and specials, initial here to opt out _____

Is this a WCB/MVA claim? (Please circle) WCB MVA N/A

Date of Birth (dd/mm/yyyy): _____ (Age _____)

Sex: ☐ F ☐ M ☐ Other

Are you or might you be pregnant? ☐ Yes ☐ No

Alberta Health Care # _____

Occupation: _____ ☐ N/A

Employer:_____

Marital Status: _____ Spouse's Name _____

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?
Caesarian section? ….Y/N
Mother given drugs/ epidural during birth? ….. Y/N
Induced labor? ……. 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, for what? _____

If yes, who have you seen? _____
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? _____
Other: _____

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

If you have had surgeries, please list them.
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?_____

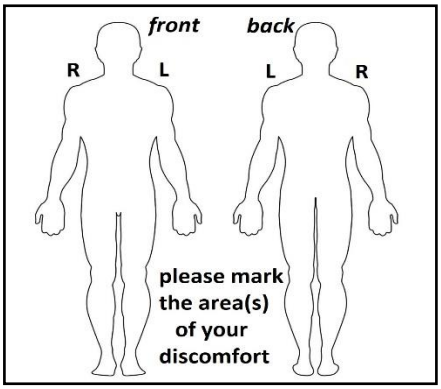
_____

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 _____

_____

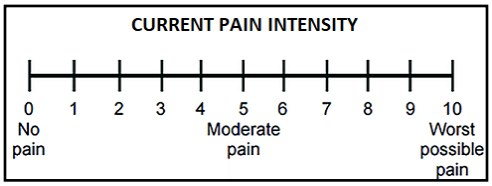
Are there other doctors/treatments that you have tried for this problem? (Please list)
☐massage therapist _____ ☐physiotherapist _____
☐acupuncturist _____ ☐medical doctor _____
☐other_____

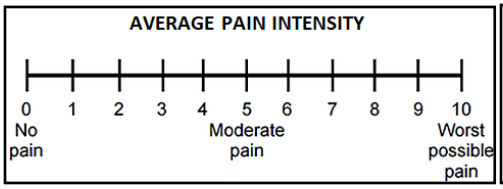
OTHER TESTS: (please circle)
Have you ever had:
X-rays / CT scan / MRI
of your :
Neck / Back / Hips-pelvis

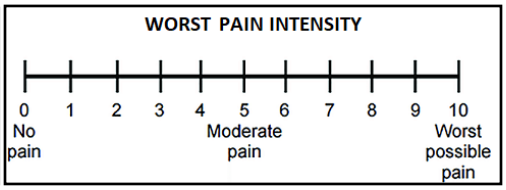
If yes, how long ago?
<7 years, >7 years

Do you remember what the results were? _____

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







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 know 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!