ELEVATION CHIROPRACTIC

HEALTH HISTORY FORM

Today's Date: _____

MB Health Number (6 digit) _____

MB Health Number (9 digit) _____

How did you hear about the clinic?
☐Referral: _____
☐Internet ☐Event ☐Live in the area

IMPORTANT: PLEASE BE AS DETAILED AS POSSIBLE. THE MORE YOU TELL ME ABOUT YOUR HEALTH CONCERNS AND ISSUES, THE BETTER I CAN HELP YOU AND THE FASTER WE CAN GET YOU TO THAT NEXT LEVEL.

PATIENT DEMOGRAPHICS

Name: _____ Birth Date: Day ___ Month___ Year___ Age:_____☐ Male ☐ Female
Address: _____ City:_____Province:_____Postal Code: _____
Home Phone #: _____ Height: _____ Weight: _____ Shoe Size: _____
Mobile Phone #: _____ E-mail Address: _____
Work Phone #: _____ Employer: _____
Name of Spouse: _____ Occupation: _____
Names & Ages of children: _____

MPI/WCB

Will you be claiming: Autopac (MPI): …. Worker's Compensation: ….
If yes: Injury/Accident Date: _____ Personal Injury Claim #: _____
How many people were in the vehicle? : _____

CHIROPRACTIC HISTORY

Have you been to a chiropractor before? Yes Name of previous chiropractor: _____
How long were you under care?:_____What were the results?:_____
Have you visited a chiropractor this **CALENDAR YEAR? ….

WHAT IS YOUR CURRENT HEALTH HOLDING YOU BACK FROM	WHY DO YOU WANT TO BE HEALTHY?
1.	1.
2.	2.
3.	3.

SYMPTOMS

Please check all that you have experienced in the last 6 months:

❑ Headaches	❑ Chest Pain	❑ Arthritis	❑ High Blood Pressure
❑ Migraines	❑ Sinus Problems	❑ Gout	❑ High Cholesterol
❑ Neck Pain	❑ Ear Infections	❑ Fatigue	❑ Heart Disease
❑ Shoulder Pain	❑ Ringing in Ears	❑ Decreased Energy	❑ Stroke
❑ Upper Back Pain	❑ Jaw Problems	❑ Difficulty Breathing	❑ Dizziness
❑ Hand/Wrist Pain	❑ Asthma	❑ Difficulty Sleeping	❑ Other:
❑ Mid Back Pain	❑ Heartburn	❑ Hot Flashes	_____
❑ Low Back Pain	❑ Carpal Tunnel Syndrome	❑ Jaundice	
❑ Stomach Pain	❑ Allergies	❑ Anxiety	
❑ Rib Pain	❑ Constipation	❑ Depression	
❑ Hip Pain	❑ Diarrhea	❑ Thyroid Condition	
❑ Knee Pain	❑ Menstrual Cramps	❑ Diabetes	
❑ Ankle Pain	❑ Ulcers	❑ Cancer	

PLEASE EXPLAIN YOUR CONDITIONS ON THE SECOND PAGE →

OFFICE USE ONLY
ID:_____
Type of Patient:
- ☐ **Regular Patient**
- ☐ **MPI Patient**
- ☐ **WCB Patient**
- ☐ **Old New Patient**
  Last Visit:_____

- ☐ **Regular New Patient**
  Insurance Coverage:_____
  - ☐ **Signed INS Forms**
  - ☐ **Signed Credit Form**
- ☐ **Free Consultation**
- ☐ **Read Subluxation Pamphlet**
- ☐ **Dr. Ryan**

Notes:

PLEASE PROCEED TO SECOND PAGE

What are the 3 problems you want the doctor to know more about?

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by ***circling the number*****:**

Problem 1._____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 _____
When did the problem(s) begin?_____How did the problem(s) begin? _____
Is the pain: ☐ Getting better ☐ Getting worse ☐ Staying the same
How often do you feel the problem? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:_____
How many hours in a day do you feel pain? ☐ 1hour ☐ 4hours ☐ 6hours ☐ 8hours ☐ 12hours ☐ Other:_____
What makes the pain better? _____
What makes the pain worse? _____
Describe the pain: _____
Is there anything else the doctor needs to know about this condition? _____

Problem 2._____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 _____
When did the problem(s) begin?_____How did the problem(s) begin? _____
Is the pain: ☐ Getting better ☐ Getting worse ☐ Staying the same
How often do you feel the problem? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:_____
How many hours in a day do you feel pain? ☐ 1hour ☐ 4hours ☐ 6hours ☐ 8hours ☐ 12hours ☐ Other:_____
What makes the pain better? _____
What makes the pain worse? _____
Describe the pain: _____
Is there anything else the doctor needs to know about this condition? _____

Problem 3._____: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 _____
When did the problem(s) begin?_____How did the problem(s) begin? _____
Is the pain: ☐ Getting better ☐ Getting worse ☐ Staying the same
How often do you feel the problem? ☐ Daily ☐ Weekly ☐ Monthly ☐ Other:_____
How many hours in a day do you feel pain? ☐ 1hour ☐ 4hours ☐ 6hours ☐ 8hours ☐ 12hours ☐ Other:_____
What makes the pain better? _____
What makes the pain worse? _____
Describe the pain: _____
Is there anything else the doctor needs to know about this condition? _____

***MARK 'X'** anywhere you feel pain:

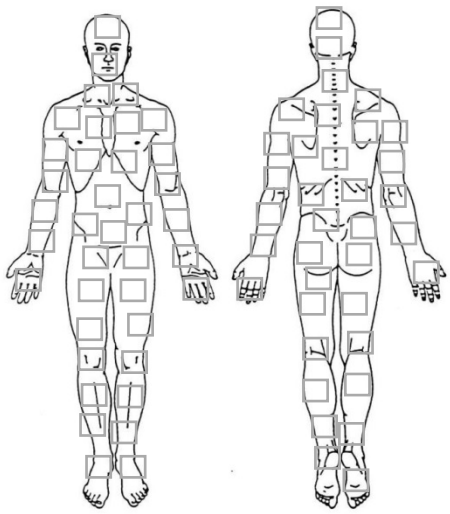
<u>Numerical Pain Scale</u>
0 = No Pain

5 = Moderate Pain

8 = Childbirth

10= Most severe pain imaginable

_____



PLEASE PROCEED TO THIRD PAGE

FAMILIAL HISTORY

Do you have a family history of the following diseases?

❑ Cancer ❑ Heart Disease ❑ Diabetes ❑ None ❑ Other: _____

Who?_____ Which disease?_____

Who?_____ Which disease?_____

Who?_____ Which disease?_____

PAST ACCIDENT/TRAUMA/INJURY HISTORY

Have you ever had x-rays taken? ❑ Yes ❑ No If yes, of what? _____

How many car accidents have you been in?_____Dates: _____

Any work, sports, or other injuries? Please describe: _____

_____

_____

Any concussions?_____

_____

PAST SURGICAL HISTORY

Please list any prior surgeries you have had and dates_____

_____

_____

LIFESTYLE

What do you do for fun/recreation? _____

_____

Do you smoke? ❑ Yes ❑ No How many per day? _____

Do you drink alcohol? ❑ Yes ❑ No How many per week? _____

Do you drink coffee, tea or soda? ❑ Yes ❑ No How many per week? _____

Do you exercise regularly? ❑ Yes ❑ No How many times per week? _____

What do you do for exercise? _____

MEDICATIONS

Who is your medical doctor? _____

Please list all medications you are taking. How long have you been taking these medications?

_____How long? _____

_____How long? _____

_____How long? _____

_____How long? _____

_____How long? _____

_____How long? _____

What vitamins, minerals, or herbs do you currently take?

_____

_____

WOMEN'S HEALTH

Are you pregnant? ❑ Yes ❑ No Are you nursing? ❑ Yes ❑ No

Are you taking birth control medication (pill, injection, other)? ❑ Yes ❑ No

FOOT HEALTH

Do you experience any of the following:

❑Sit or stand long periods of time ❑Ankle swelling

❑Bunions ❑Arthritis

❑Flat feet ❑Sore, tired, achy legs

❑Varicose Veins ❑Imprints from your socks on your legs?

Do you wear:

❑ Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Arch Supports ❑None

Please mark anywhere you feel pain: