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: ____
Address: ____
Home Phone #: _______________________________________
Mobile Phone #: ______________________________________
Work Phone #:____
Name of Spouse: ______________________________________
Names & Ages of children: ____________________________

Birth Date: Day ___ Month___ Year___ Age:_____☐ Male ☐ Female
City:______________________Province:______Postal Code: __________
Height: ____________ Weight: ____________ Shoe Size: ____________
E-mail Address: ____
Employer: ____
Occupation: ____

MPI/WCB

Will you be claiming: Autopac (MPI): Y/N Worker's Compensation: Y/N
If yes: Injury/Accident Date: ______________________________ Personal Injury Claim #: ___________________________
How many people were in the vehicle? :______________________

CHIROPRACTIC HISTORY

Have you been to a chiropractor before? Y/N Name of previous chiropractor: _____________________________________
How long were you under care?:________________________What were the results?:______________________________

WHAT IS YOUR CURRENT HEALTH HOLDING YOU BACK FROM

1.
2.
3.

WHY DO YOU WANT TO BE HEALTHY?

1.
2.
3.

SYMPTOMS

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

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

PLEASE EXPLAIN YOUR CONDITIONS ON THE SECOND PAGE →

OFFICE USE ONLY
ID:_______________
Type of Patient:
- ☐ **Regular Patient**
- ☐ **Corporate Wellness:** _____________________
- ☐ **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? ____

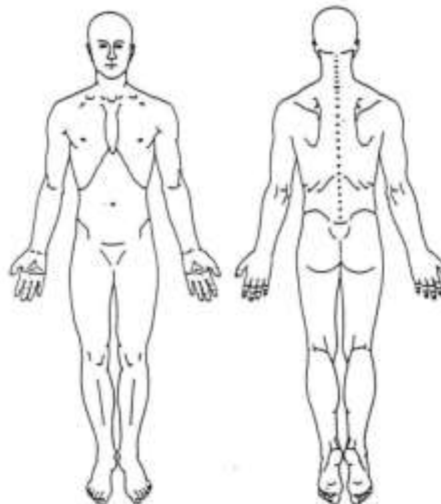
***MARK ‘X’** anywhere you feel pain:

<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: