SOUND CHIROPRACTIC & WELLNESS CLINIC

PATIENT HEALTH HISTORY

Name:_________________________ Date of Birth(dd/mm/yyyy):___________________________

What brings you to the clinic?

____

____

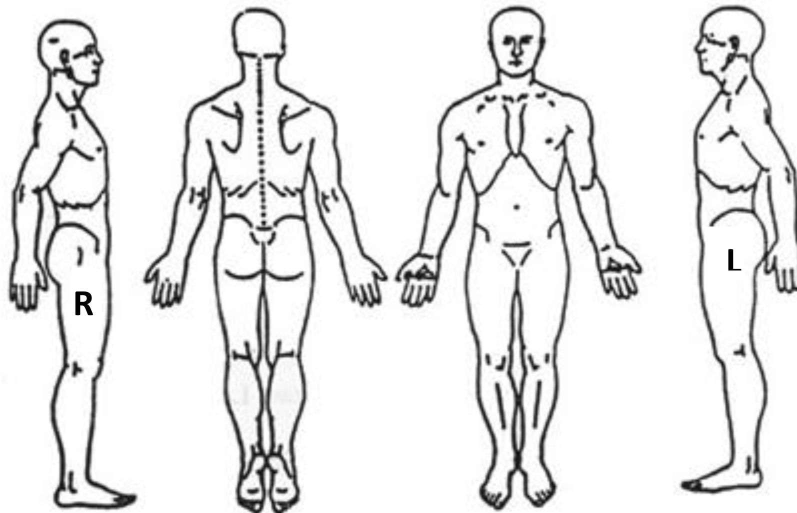
____

____

Please mark the areas of pain on the diagrams using the keys below:

Type of pain	
Sharp	XXXX
Dull	ooooo
Numb	~~~~~
Stabbing	22222

Intensity of pain	
Very Mild	1
Mild	2
Moderate	3
Severe	4
Very Severe	5



Have you had **X-rays** taken of the problem area?

No ☐ Yes ☐ If so;

When_________________________________

Where________________________________

Medical Doctor

Name:_________________________________

Phone:________________________________

Current Medications

Name	For what condition

Past surgeries

Date(s)________________________________

Type(s)________________________________

Past Injuries

Date(s)________________________________

Type(s)________________________________

Life Style

Please check the boxes that apply:

	Never	Occasionally	Daily
Caffeine	☐	☐	☐
Insomnia	☐	☐	☐
Smoking	☐	☐	☐
Alcohol	☐	☐	☐
Exercise	☐	☐	☐

Over >

1110 8th St. East, Owen Sound, ON N4K 3T9 Tel: (519) 376-5657 www.soundchiros.ca

SOUND CHIROPRACTIC & WELLNESS CLINIC

PATIENT HEALTH HISTORY

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let your provider know immediately. All information gathered is confidential. You will be asked to provide written authorization for release of any information.

Please indicate conditions you are experiencing or have experienced in the past:

Musculoskeletal
☐Lower back pain
☐Upper back pain
☐Neck pain / stiffness
☐Shoulder pain / stiffness
☐Hip / Leg / Knee pain or numbness
☐Foot / Ankle pain or numbness
☐Arthritis
☐Bursitis
☐Sciatica

Head / Neck Headaches
☐Migraine
☐Blurred vision
☐Double vision
☐Earache
☐Dizziness
☐Ringing in Ears
☐Nose bleeds
☐Sinus infections

Cardiovascular
☐High blood pressure
☐Low blood pressure
☐Heart disease
☐Poor circulation
☐Palpitation
☐Angina
☐Swelling of ankles
☐Varicose veins
☐Stroke
☐Abnormal heart beat
☐Pacemaker

Respiratory
☐Chronic cough
☐Chest pain
☐Shortness of breath
☐Asthma
☐Emphysema

Skin
☐Bruise easily
☐Skin dryness
☐Rashes
☐Eczema

Gastrointestinal
☐Abdominal pain
☐Constipation
☐Diarrhea
☐Indigestion
☐Gallbladder trouble
☐Hemorrhoids
☐Hepatitis
☐Excessive gas
☐Irritable Bowel

Women only
☐Breast tenderness
☐Menstrual cramps
☐Irregular cycle
☐PMS
☐Menopausal symptoms
☐Vaginal spotting
☐Vaginal discharge

Urinary
☐Frequent urination
☐Painful urination
☐Blood / Pus in urine
☐Incontinence
☐Urinary urgency
☐Difficulty emptying bladder
☐Interstitial cystitis
☐Kidney problems

Other conditions
☐Diabetes
☐Cancer
☐Anemia
☐Convulsions
☐Allergies
☐Epilepsy

Doctor's Notes

	#	Any complications
Pregnancies		
Miscarriages		
D&C		
Other surgeries		

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