Binbrook Family Chiropractic & Physiotherapy 3064 Highway 56 Binbrook, ON L0R1C0

# HEALTH HISTORY FORM

***For Your Information:***
An accurate health history is important to ensure that it is safe for you to receive a treatment. If your health status changes in the future, please let us now. All information gathered for this treatment is confidential except as required or allowed by law or to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Preferred Name (if any): _____

Address: _____ Today's Date: _____

City: _____ Postal Code: _____

Telephone Number (Home): _____ (Cell): _____

Emergency Contact (Name and Phone Number): _____

**Would you like a reminder call/text for your appointments? Y/N**

E-mail Address: _____

Date of Birth: _____/_____/_____ Gender: M / F Occupation: _____
Month Day Year

Primary Care Physician: _____ Address: _____

Previous Chiro / Physio / Massage Care:_____ Last seen:_____

For what condition:_____ Results:_____

MVA or WSIB Claim number: _____

**Health History**: please indicate conditions you are experiencing, or have experience.

**Cardiovascular**
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ CCHF
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart palpations
- ☐ Heart murmur
- ☐ Aneurism
- ☐ Angina
- ☐ Blood Clots
- ☐ Raynaud's Disease
- ☐ Phlebitis/Varicose Veins
- ☐ Pace Maker/Similar Device
- ☐ Stroke/CVA
- ☐ Other _____

**Blood**
- ☐ Anemia
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Hepatitis A B C

**Respiratory**
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sinus Congestion
- ☐ other _____

**Gastrointestinal**
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/Bloating
- ☐ Nausea/Vomiting
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's/Colitis
- ☐ Hernia
- ☐ Ulcers
- ☐ Gall Bladder Problems
- ☐ Liver Problems
- ☐ Kidney Infections
- ☐ Bladder Infections
- ☐ Urination Problems
- ☐ Poor Appetite
- ☐ Excessive Thirst

**Skin**
- ☐ Allergies:
- ☐ Hypersensitivity
- ☐ Bruises Easily
- ☐ Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Athletes Foot
- ☐ Herpes
- ☐ Warts
- ☐ Skin Conditions:

**Family History**
- ☐ arthritis
- ☐ cancer
- ☐ diabetes
- ☐ heart disease/stroke

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**Cigarette/Tobacco Consumption**
- ☐ yes – amount _____/day
- ☐ no

**Other Conditions**
- ☐ diabetes: onset _____
- ☐ HIV/AIDS
- ☐ Cancer
  Type?
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Thyroid Disorders
- ☐ Lupus
- ☐ arthritis
- ☐ migraines &/or headaches
- ☐ Loss of Sensation
  Where?
- ☐ Insomnia/Fatigue
- ☐ Fainting/Dizziness
- ☐ Anxiety/Nervousness
- ☐ Depression
- ☐ Alcohol/Drug Problem

**Women**
- ☐ pregnant: - due: _____
- ☐ Infertility
- ☐ Menstrual Concerns/Pain
- ☐ Menopausal Concerns
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Hysterectomy
- ☐ Vaginal Pain/Infection

**Head/Neck**
- ☐ Headaches
- ☐ Migraines
- ☐ Whiplash
- ☐ Jaw Pain
- ☐ Hearing Problems
- ☐ Hearing Loss
- ☐ Vision Problems
- ☐ Vision Loss

**Soft Tissue/Joint Discomfort**
- ☐ Neck
- ☐ Muscle Strain
- ☐ Ligament Sprain
- ☐ Spasms/Cramps
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Fibromyalgia
- ☐ Ankylosing Spondylitis
- ☐ Arthritis OA RA
- ☐ Osteoporosis
- ☐ Herniated Disc
- ☐ Degenerative Disc
- ☐ Joint or Bone Disease
- ☐ Scoliosis
- ☐ Dislocation
- ☐ Fracture
- ☐ Low Back
- ☐ Mid Back
- ☐ Upper Back
- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ other _____

**Rate your General Health**
- ☐ above average
- ☐ average
- ☐ below average

**Are you currently taking any medications?** _____

What is your **Current complaint?** _____

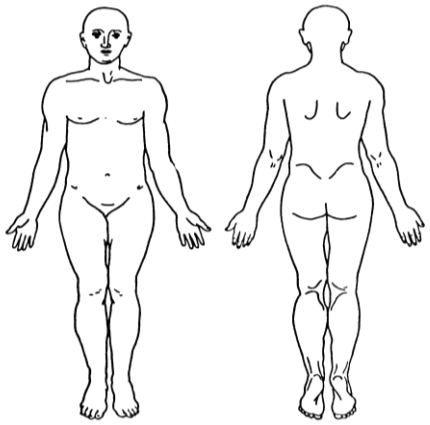
Has this condition occurred before? Yes/No

When did this condition begin? _____

Is the condition: ☐ Job-related ☐ Auto-related
☐ Fall ☐ Home Injury ☐ Other: _____

Date of Accident: _____

What happened? _____



Please mark on the diagram the area of your discomfort and any radiation of pain.

**Circle the grade to indicate the severity of your pain:**

LEAST 0 1 2 3 4 5 6 7 8 9 10 WORST

Have you gone for any x-rays, ultrasounds, MRI's etc. for ***this injury/problem?*** YES / NO

If YES, where? _____and approximately when? _____

Surgeries/Major Injuries (Nature/Date): _____

Presence of internal pins, wires, artificial joints, special equipment, etc._____

What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Dow ☐ Cold ☐ Dampness ☐ Other: _____

What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐Medication
☐ Other: _____

Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb
☐ Burning ☐ Intermittent ☐ Constant

Does the pain radiate anywhere? ☐ No ☐Arm (L or R) ☐Leg (L or R) ☐Other: _____

When does it hurt? ☐Morning ☐ Evening ☐wakes me up at night ☐ Other: _____

Please describe how it feels when this problem is at its worse: _____

**How did you hear about Binbrook Family Chiropractic?☐** Referral from Doctor ☐ Friend/Patient ☐ Sign ☐ Flyer/Advertisement ☐ Other: _____