CONFIDENTIAL PATIENT HEALTH RECORD

RIVER OAKS CHIROPRACTIC & WELLNESS CENTRE

Name: _____ Birthdate: M / D / Y Gender: □ M □ F File No.: _____

Address: _____City/Province: _____Postal Code: _____

Home Phone: _____ Business Phone: _____ Email: _____

Employer: _____ Type of Work: _____

Circle One: Married Single Widowed Divorced Separated Other Number of Children: _____

Emergency Contact: _____ Phone Number: _____

Who may we thank for referring you to this office? _____

CURRENT HEALTH CONDITION

Current Health Complaint(s): _____

When did this begin? _____

Has the condition occurred before? □ Yes □ No When? _____

Is the condition: □ Job Related □ Auto Related □ Home Injury □ Fall □ Other: _____

What does it feel like: □ Sharp □ Dull □ Ache □ Pins & Needles □ Numb □ Burning □ Other: _____

Frequency of Pain: □ Constant □ Intermittent If intermittent, how often? _____

How long does each episode last? _____ When was your last episode? _____

Has the condition been getting: □ Worse □ Better □ Stayed the Same

What aggravates the condition? _____

What makes the condition feel better? _____

Does your pain radiate anywhere (e.g. into arms or legs)? □ Y □ N Where? _____

What activities are you unable to do because of this condition? _____

Have you had any previous injuries to the area of your complaint? □ Y □ N When? _____

Have you seen another health professional for this condition? □ Y □ N Who? _____

What previous treatments have you received for this condition? _____

Previous Chiropractic care? □ Y □ N Who? _____ Last Visit / /

What was your previous Chiropractic care for? _____ Did it help? □ Y □ N

Please indicate the level of improvement you expect from Chiropractic treatment of your condition:

□ 0% □ 25% □ 50% □ 75% □ 100%

Please indicate which type of chiropractic care you would like:

- □ Relief care - alleviates your symptoms but not the cause
- □ Corrective Care - alleviates your symptoms or pain and corrects the cause of the problem
- □ Maintenance Care - regular treatment to prevent symptoms from occuring

Patient: _____

File No.: _____

SYSTEMS REVIEW

Below is a list of diseases and symptoms which may seem unrelated to the purpose of your appointment. However, it is important that you **check any that you have currently or have had in the past** as these may affect the overall course of your chiropractic care.

NERVOUS SYSTEM

- □ Nervous
- □ Numbness
- □ Paralysis
- □ Dizziness
- □ Forgetfulness
- □ Confusion
- □ Depression
- □ Fainting
- □ Convulsions
- □ Seizures
- □ Cold / Tingling (hands/feet)
- □ Multiple Sclerosis
- □ Alzheimers
- □ Dementia
- □ Other: _____

MUSCLES/JOINTS

- □ Low Back Pain
- □ Pain Between Shoulders
- □ Neck Pain
- □ Arm Pain
- □ Elbow Pain
- □ Wrist Pain
- □ Shoulder Pain
- □ Knee Pain
- □ Hip Pain
- □ Foot Pain
- □ Plantar Fasciitis
- □ Pain / Clicking Jaw
- □ Joint Pain / Stiffness
- □ General Stiffness
- □ Bone Cancer
- □ Other: _____

EARS/NOSE/THROAT

- □ Double/Blurry Vision
- □ Dental Problems
- □ Sore Throat
- □ Ear Aches
- □ Hearing Difficulty
- □ Sinus Congestion
- □ Postnasal Drip
- □ Nasal Polyps
- □ Cataracts
- □ Glaucoma
- □ Environmental Allergies
- □ Other: _____

HEART

- □ Chest Pain
- □ Shortness of Breath
- □ High / Low Blood Pressure
- □ Irregular Heart Beat
- □ Heart Problems
- □ Varicose Veins
- □ Ankle Swelling / Edema
- □ Stroke
- □ Pacemaker
- □ Heart Attack
- □ Bypass Surgery
- □ Other: _____

RESPIRATORY

- □ Lung Problems
- □ Pneumonia
- □ Asthma
- □ Tuberculosis
- □ Lung Cancer
- □ Other: _____

DIGESTION

- □ Poor/Excessive Appetite
- □ Excessive Thirst
- □ Frequent Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Hemorrhoids
- □ Liver Problems
- □ Gall Bladder Problems
- □ Weight Trouble
- □ Abdominal Cramps
- □ Gas / Bloating After Meals
- □ Heartburn
- □ Ulcer
- □ Other: _____

BOWEL/BLADDER

- □ Colitis
- □ Irritable Bowel Syndrome
- □ Black / Bloody Stool
- □ Discoloured Urine
- □ Painful Urination
- □ Painful Bowel Movement
- □ Frequent Urination
- □ Bowel / Bladder Cancer
- □ Other: _____

GENERAL

- □ Fatigue
- □ Medicinal Allergies
- □ Loss of Sleep
- □ Fever
- □ Headaches
- □ Cancer

MALE

- □ Prostate Problem
- □ Sexual Dysfunction
- □ Breast Pain/Lumps
- □ Breast Cancer
- □ Prostate Cancer
- □ Other: _____

FEMALE

- □ Menstrual Irregularity
- □ Menstrual Cramping
- □ Vaginal Pain
- □ Yeast Infections
- □ Breast Pain/Lumps
- □ Breast Cancer
- □ Endometriosis
- □ Uterine / Ovarian Cancer
- □ Other: _____

When was your last period?

/ /

Are you pregnant? □ Y □ N

Due Date: / /

INTAKE

- □ Coffee
- □ Tea
- □ Alcohol
- □ Cigarettes
- □ White Sugar

DIET

- □ Vegetarian
- □ Lactose Intolerant
- □ Glutein Intolerant
- □ Food Allergies
- □ Other: _____

LIFESTYLE STRESS

- □ High
- □ Moderate
- □ Little

Patient: _____

File No.: _____

HEALTH HISTORY

Current Family Doctor: _____ Approximate Date of Last Physical Exam: / /

Current Weight: _____ Height: _____ Any recent weight: □ Loss □ Gain How much? _____

Please indicate if you have had any surgeries/operations/hospitalizations:

□ Appendix □ Tonsils □ Gall Bladder □ Hernia □ Back Surgery □ Broken Bones: _____

□ Other: _____

Have you had any previous:

□ Childhood Traumas: _____ When? _____

□ Sports Injuries: _____ When? _____

□ Auto-accidents: _____ When? _____

□ Work Injuries: _____ When? _____

Do you have any medical conditions: _____

Are you currently taking any medications or supplements: _____

Have you had any of the following done in the last six months: □ X-ray □ Ultrasound □ MRI □ CT scan

Have you had any blood work done in the last year? □ Y □ N If yes, why? _____

Is there any member of your family who has the following:

□ Diabetes □ Cancer □ Arthritis □ Stroke □ Neurological Disorder □ Blood Pressure Problem

□ Heart Problem □ Seizures/Convulsions □ Similar Condition To Your Current Complaint

Check any of the following diseases you have had or currently have:

□ Rheumatic Fever	□ Measles	□ Chicken Pox	□ Cancer	□ Epilepsy
□ Polio	□ Mumps	□ Small Pox	□ Thyroid	□ Eczema
□ Whooping Cough	□ HIV	□ Hepatitis	□ Influenza	□ Shingles
□ Anemia	□ AIDS	□ Diabetes	□ Pleurisy	

Do you smoke? □ Y □ N □ Quit: how long? _____ If smoke, how many packs/day? _____ For how long? _____

How many hours of sleep do you get a night? _____ Do you feel rested when you wake up? □ Y □ N

What position do you sleep in? □ Side □ Back □ Stomach

How old is your mattress and pillow? _____

How often do you exercise? □ Daily □ Every other day □ Weekly □ Infrequent □ None

Are there any other conditions that you suffer that you would like Dr. McGlashan to address? □ Y □ N

_____

Please provide any additional details or concerns you have that were not already addressed in this form:

_____

_____

_____

_____

_____

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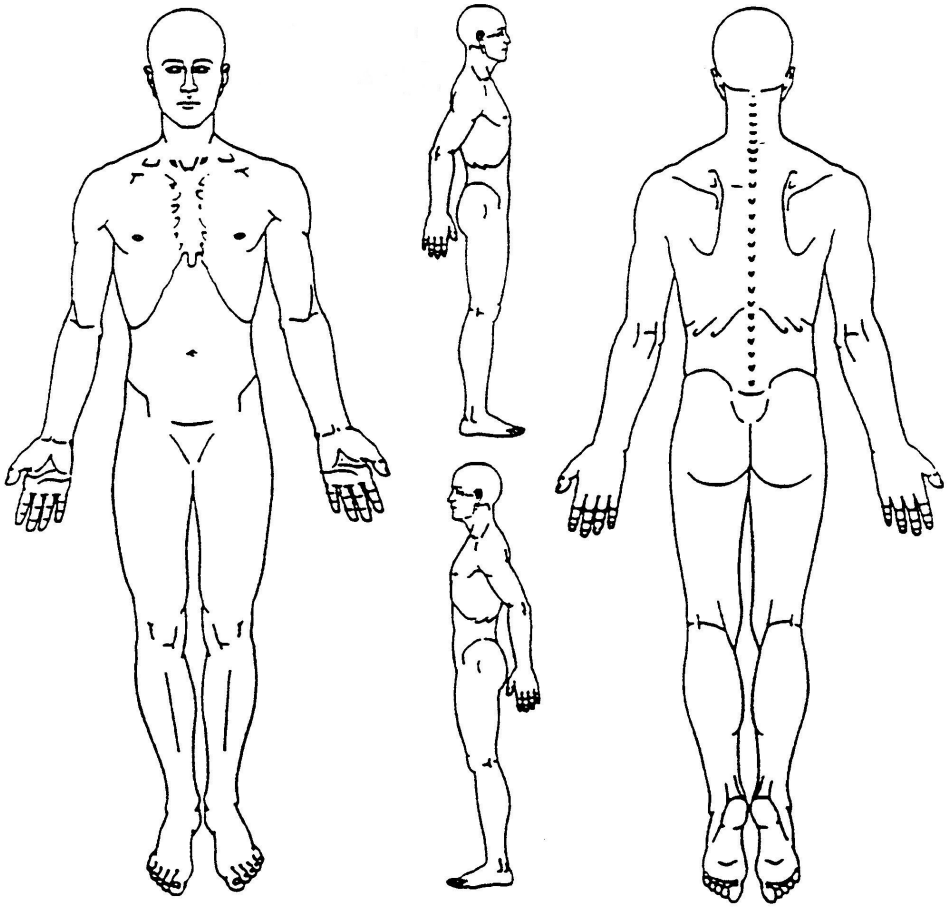
To help us better understand where your injury or pain is located please use the body diagrams below to label any of the following symptoms you may be feeling currently:

Burning - XXXX	**Stabbing** - ////	**Stiffness** - SSSS	**Pins and Needles** - 0000
Numbness - ====	**Aching** - Δ Δ Δ Δ	**Tension** - TTTT	**Throbbing**—####



Please rate the severity of your pain **CURRENTLY** by circling one of the numbers below:

0 1 2 3 4 5 6 7 8 9 10

O—No pain
1—Mild pain, you are aware of it, but it doesn't bother you
2—Moderate pain that you can tolerate without medication
3—Moderate pain that requires medication to tolerate
4-5—More severe pain, it limits your ability to do things
6—Severe pain
7—9 Intensely severe pain
10—Most severe pain—Emergency Room Care