DISCOVER
HEALTH CENTRE

· Discover Your Health Potential ·

Welcome to Discover Health Centre, please fill out the following information and pass it back to the front desk. Thank you!

Treating Practitioner ______________ Pt# _____

First Name ________________

Middle Initial ____________________

Last Name ________________

Address ________________________ Apt# ______

City ____________ Prov. ____ Postal Code ______

Who referred you to this office? ______________________

Date of Birth ____ / ____ / ____ Age: __ Gender: M / F
day / month / year

Phone Number: Home _________

Work _________

e-mail __________

Are you a student? YES I NO

HEALTH CARD NUMBER ________________

VERSION CODE ____ EXPIRY DATE ______

Are you seeing another practitioner in our center? If so who? _________

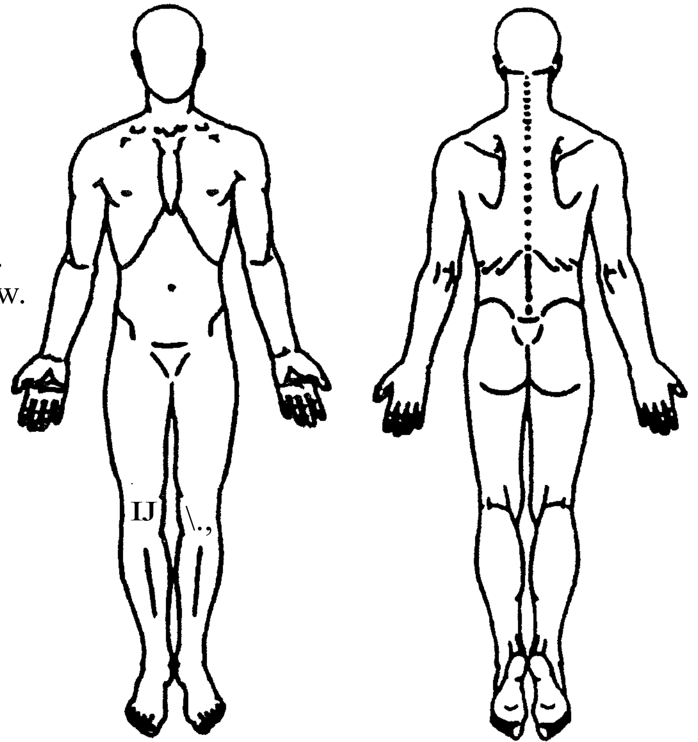
Have you been to another chiropractor before? Yes/No
If yes, who and when ______________________

Results? Excellent Good Fair Poor

Medical Doctor Name and Address ____________________

Patient History Form Name: __________ Patient# ____

1. What is your reason for seeking Chiropractic care?



2. Please indicate area(s) of pain or unusual feeling. Mark the areas on the body where you feel the following sensations using the appropriate symbols. Mark areas of radiation/travelling pain with an arrow.

Numbness	......••.... ..•.•.•.....
Sharpness	00000000 00000000
Burning	XXXXXX XXXXXX
Aching	********* *********
Stiffness	>>>>>>>> >>>>>>>>

3. If you are experiencing symptoms, how long and how often have they been bothering you?

4. Do you know what caused the latest episode? Have you had this problem in the past?

5. On a scale from 0-10, (10 being the worst) rate your pain: / 10

6. What provides you with relief? What aggravates your condition?

7. List any conditions (fibromyalgia, diabetes, stroke, osteoporosis etc.) you have had and when?

8. What are your expectations from Chiropractic care?

PATIENT PAST HISTORY FORM

Name: ____________________ _ Date: ________ _

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

C = Constant F = Frequent 0 = Occasional

C F 0

NEUROLOGICAL

☐ ☐ ☐ allergy
☐ ☐ ☐ chills
☐ ☐ ☐ convulsions
☐ ☐ ☐ dizziness
☐ ☐ ☐ fainting
☐ ☐ ☐ fevers
☐ ☐ ☐ headaches
☐ ☐ ☐ loss of sleep
☐ ☐ ☐ nervousness
☐ ☐ ☐ depression
☐ ☐ ☐ neuralgia
☐ ☐ ☐ numbness
☐ ☐ ☐ sweats
☐ ☐ ☐ loss of weight
☐ ☐ ☐ tremors

MUSCLE & JOINT

☐ ☐ ☐ arthritis
☐ ☐ ☐ bursitis
☐ ☐ ☐ foot trouble
☐ ☐ ☐ hernia
☐ ☐ ☐ low back pain
☐ ☐ ☐ neck pain
☐ ☐ ☐ neck stiffness
☐ ☐ ☐ pain between shoulders

RESPIRATORY

☐ ☐ ☐ chest pain
☐ ☐ ☐ chronic cough
☐ ☐ ☐ difficulty breathing
☐ ☐ ☐ spitting blood
☐ ☐ ☐ throat phlegm
☐ ☐ ☐ wheezing

EYES,EARS, NOSE & THROAT

☐ ☐ ☐ colds
☐ ☐ ☐ crossed eyes
☐ ☐ ☐ deafness
☐ ☐ ☐ dental decay
☐ ☐ ☐ asthma
☐ ☐ ☐ ear aches
☐ ☐ ☐ ear discharges
☐ ☐ ☐ ear noises

C F 0

☐ ☐ ☐ sinus infections
☐ ☐ ☐ enlarged glands
☐ ☐ ☐ enlarged thyroid
☐ ☐ ☐ sore throat
☐ ☐ ☐ tonsillitis
☐ ☐ ☐ eyepain
☐ ☐ ☐ failing vision
☐ ☐ ☐ far sighted
☐ ☐ ☐ gum trouble
☐ ☐ ☐ hay fever
☐ ☐ ☐ hoarseness
☐ ☐ ☐ nasal obstruction
☐ ☐ ☐ near sighted
☐ ☐ ☐ nosebleeds

CARDIO-VASCULAR

☐ ☐ ☐ rapid heart beats
☐ ☐ ☐ slow heart beat
☐ ☐ ☐ swelling of ankles
☐ ☐ ☐ hardening of arteries
☐ ☐ ☐ high blood pressure
☐ ☐ ☐ low blood pressure
☐ ☐ ☐ pain over heart
☐ ☐ ☐ poor circulation

GASTRO INTESTINAL

☐ ☐ ☐ excessive hunger
☐ ☐ ☐ burping or gas
☐ ☐ ☐ livertrouble
☐ ☐ ☐ colitis
☐ ☐ ☐ colon trouble
☐ ☐ ☐ constipation
☐ ☐ ☐ diarrhea
☐ ☐ ☐ difficult digestion
☐ ☐ ☐ distension of abdomen
☐ ☐ ☐ stomach pain
☐ ☐ ☐ gall bladder trouble
☐ ☐ ☐ hemorrhoids
☐ ☐ ☐ intestinal worms
☐ ☐ ☐ jaundice
☐ ☐ ☐ poor appetite
☐ ☐ ☐ nausea
☐ ☐ ☐ vomiting
☐ ☐ ☐ vomit blood

C F 0

SKIN

☐ ☐ ☐ boils
☐ ☐ ☐ bruise easily
☐ ☐ ☐ dryness
☐ ☐ ☐ hives or allergy
☐ ☐ ☐ itching
☐ ☐ ☐ skin rash
☐ ☐ ☐ varicose veins

GENITO-URINARY

☐ ☐ ☐ bet wetting
☐ ☐ ☐ blood in urine
☐ ☐ ☐ frequent urination
☐ ☐ ☐ loss control urine
☐ ☐ ☐ kidney infection
☐ ☐ ☐ painful urination
☐ ☐ ☐ prostate trouble
☐ ☐ ☐ pus in urine
☐ ☐ ☐ smell of urine

PAIN OR NUMBNESS IN:

☐ ☐ ☐ shoulders
☐ ☐ ☐ arms
☐ ☐ ☐ hands
☐ ☐ ☐ hips
☐ ☐ ☐ legs
☐ ☐ ☐ knees
☐ ☐ ☐ ankles
☐ ☐ ☐ feet
☐ ☐ ☐ painful tail bone
☐ ☐ ☐ sciatica
☐ ☐ ☐ swollen joints

FOR WOMEN ONLY

☐ ☐ ☐ cramps
☐ ☐ ☐ heavy flow
☐ ☐ ☐ light flow
☐ ☐ ☐ irregular cycle
☐ ☐ ☐ painful cycle
☐ ☐ ☐ discharge
☐ ☐ ☐ sore breasts

Menopausal: ☐ Yes ☐ No
Last menstration date:

____

Pregnant: ☐ Yes ☐ No
due date: _____ _

PATIENT PAST HISTORY FORM (continued)

HABITS OF LIFESTYLE:

Do you smoke: ☐ Yes ☐ No Doyou consume alcohol: ☐ Yes ☐ No

Do you exercise: ☐ Yes ☐ No Exercise Indoor Activities:

Exercise Oudoor Activities: _________ _

Rate your sleep, hours per night: 4 - 6 6 - 8 8 - 10 12+

Do you wake rested: ☐ Yes ☐ No

Rate your appetite: Poor Fair Medium Good Excellent

Rate your diet: Poor Fair Medium Good Excellent

Do you eat regularly: Breakfast Lunch Dinner

Do you eat per day: 1 meal 2 meals 3 meals 4 meals More than 4 meals

Date of last Dental Examination: _________________________ _

Falls and Accidents - list: ____

____

Surgery and Operations - list: __________________________ _

____

Surgery recommended but not performed, list: ____________________ _

____

Do you take vitamins and minerals, list: ☐ Yes ☐ No

____

Have you ever been knocked unconscious: ☐ Yes ☐ No ☐ Don't know

If so, for how long: ________________ _

List any medication or drugs you are currently taking: _________________ _

____

____

Have you previously been hospitalized: ☐ Yes ☐ No

Please list: _________________________________ _

Any family health conditions or problems: ☐ Yes ☐ No

Please list: _________________________________ _

Signature: ____________________ _ Date: _______ _