

Norfolk Chiropractic

Wellness Centre

PATIENT HEALTH HISTORY

Please complete this questionnaire. Your answers will help us determine how Chiropractic can help you. If we do not believe your condition will respond satisfactorily, we will not accept your case.

NAME _____		INITIAL VISIT DATE _____	
ADDRESS _____		CITY _____	POSTAL CODE _____
HOME PHONE # _____	WORK PHONE # _____		
E-MAIL _____	SEX M / F	BIRTH DATE _____ (DAY/ MONTH/ YEAR)	
HEIGHT _____	WEIGHT _____	FAMILY DOCTOR _____	
OCCUPATION _____		EMPLOYER _____	

Have you had **Chiropractic care before?** Yes / No Dr. _____ Last Visit: _____

Have you ever had **Spinal X-rays taken?** Yes / No Reason: _____ Date: _____

Please circle present conditions and check (✓) previous conditions.

GENERAL SYMPTOMS

- | | | | |
|-------------------------|-----------------------|---------------------------|-------------------------|
| HEADACHES | SORE THROAT | LOW BLOOD PRESSURE | PROSTATE TROUBLE |
| MIGRAINES | HOARSENESS | CHEST PAIN ON ACTIVITY | GASTROINTESTINAL |
| FEVER | ASTHMA | PREVIOUS STROKE | POOR APPETITE |
| CHILLS | CHRONIC COUGH | HARDENING OF ARTERIES | DIFFICULT DIGESTION |
| SWEATS | FREQUENT COLDS | SWOLLEN ANKLES | EXCESSIVE HUNGER |
| FAINTING | ENLARGED THYROID | POOR CIRCULATION | BELCHING |
| DIZZINESS | TONSILITIS | MUSCLE & JOINT | HEARTBURN |
| SEIZURES | SINUS INFECTION | NECK ACHE | NAUSEA |
| CONVULSIONS | ENLARGED GLANDS | BACKACHE | VOMITING |
| LOSS OF SLEEP | SKIN | SWOLLEN JOINTS | STOMACH PAIN |
| FATIGUE | ITCHING | PAINFUL TAILBONE | CONSTIPATION |
| NERVOUSNESS | RASHES | FOOT PAIN | DIARRHEA |
| LOSS OF WEIGHT | BRUISING EASILY | SHOULDER PAIN | FLATULENCE |
| NUMBNESS OR TINGLING IN | VARICOSE VEINS | KNEE PAIN | HEMORRHOIDS |
| ARMS, LEGS OR HANDS | SENSITIVE SKIN | HERNIA | LIVER TROUBLE |
| ALLERGIES | HIVES | SPINAL CURVATURE | GALL BLADDER TROUBLE |
| WHEEZING | RESPIRATORY | FAULTY POSTURE | JAUNDICE |
| E.E.N.T. | CHRONIC COUGH | ARTHRITIS | COLITIS |
| FAILING VISION | SPITTING UP PHLEGM | GENITOURINARY | WOMEN ONLY |
| NEAR SIGHTED | CHEST PAIN WITH | FREQUENT URINATION | PAINFUL MENSTRUATION |
| FAR SIGHTED | BREATHING | PAINFUL URINATION | EXCESSIVE FLOW |
| EYE PAIN | DIFFICULT BREATHING | BLOOD IN URINE | HOT FLASHES |
| HEARING LOSS | CARDIOVASCULAR | KIDNEY INFECTION | IRREGULAR CYCLE |
| EARACHE | RAPID HEART BEAT | KIDNEY STONES | CRAMPS OR BACKACHE |
| RINGING IN EARS | SLOW HEART BEAT | BED WETTING | CONGESTED BREAST |
| NOSEBLEEDS | HIGH BLOOD PRESSURE | BLADDER INCONTINANCE | LUMPS IN BREAST |

Have you ever had any of the following diseases/conditions?

- | | | | | | |
|---------------|--------------|-----------------|------------------|-----------------|----------------------|
| HYPERTENSION | MUMPS | EPILEPSY | CHICKEN POX | DIPHTHERIA | OSTEOARTHRITIS |
| HEART DISEASE | MEASLES | DIABETES | SHINGLES | POLIO | RHEUMATOID ARTHRITIS |
| LUNG DISEASE | RUBELLA | ANEMIA | MONONUCLEOSIS | INFLUENZA | GOUT |
| CANCER | MALARIA | HYPERTHYROIDISM | VENEREAL DISEASE | SCARLET FEVER | PSORIASIS |
| STROKE | TUBERCULOSIS | HYPOTHYROIDISM | ALCOHOLISM | RHEUMATIC FEVER | SCOLIOSIS |

Other (specify): _____

Has anyone in your family had any of the following conditions/diseases?

- | | | | |
|---------------|--------------------|------------------------|--------------------|
| HYPERTENSION | DIABETES | SCOLIOSIS | LOW BACK PAIN |
| HEART DISEASE | TUBERCULOSIS | RHEUMATOID ARTHRITIS | DISC DISEASE |
| LUNG DISEASE | MULTIPLE SCLEROSIS | ANKYLOSING SPONDYLITIS | SPINAL SURGERY |
| STROKE | ALZHEIMERS DISEASE | OSTEOARTHRITIS | MIGRAINE HEADACHES |
| CANCER | GOUT | OSTEOPOROSIS | EPILEPSY |

Other (specify): _____

List any medications you currently take: _____

List any surgeries you have had in the past: _____