Health First Rehab | Family Chiropractic

CONFIDENTIAL ADULT PATIENT HEALTH RECORD

Date:

1020 Brock Rd. Unit 1008 Pickering, ON L1W 3H2
905-492-3244 | Info@pickeringrehab.com

PERSONAL INFORMATION

First Name:	Last Name:	Sex: □ M □ F
Date Of Birth:	Marital Status:	# of Children:
Street Address:		Height:
City, Prov., Postal:		Weight:
Occupation:		
Email:	Cell Phone:	Other Phone:
Emergency Contact:	Emerg. Relation:	Emerg. Phone:

Whom shall we thank for referring you to our office?

Are you pregnant? Yes____ | No____ | Unsure____ | N/A____

Family Physician's Name: _____ Phone: _____

Address: City:

Do you consent to updating your family physician your current health status & progress made? Yes □ No □

Please Check all that apply

Cardiovascular
- □ High Blood Pressure
- □ Low Blood Pressure

Type:_____
- □ Angina
- □ Heart Attack
- □ Chronic Congestive Heart Failure
- □ Phlebitis/Varicose Veins
- □ Stroke / CVA
- □ Pacemaker (or similar Device
- □ Heart Disease
- □ Other_____

Is there a family history of any of the above? Y □ N □

Infectious Conditions
- □ Hepatitis Type:_____
- □ HIV/AIDS
- □ Tuberculosis
- □ Skin Conditions Type_____
- □ Other:_____

Respiratory
- □ Emphysema
- □ COPD
- □ Other:_____

Is there a family history of any of the above Y □ N □

Other Conditions
- □ Diabetes Type_____
- □ Cancer

Are you being treated?____

Please List all Medications

Name Used For

_____
_____
_____
_____

Is there a family history of any of the above Y □ N □

CHIEF COMPLAINTS / QUALITY OF LIFE

What is your main reason for consulting our office today?

If you have no specific symptom or complaints, and are here mainly for wellness services, please check (x) here_____ and skip to **"Family Health Profile".** Those who have symptoms or complaints continue to fill out the remaining of the form.

Would you consider this problem (circle one): MILD (annoying but causes no limitations)
MODERATE (sometimes tolerable but definitely limitations)
SEVERE (causing significant limitations)

When did you first experience the problem?

Is the condition getting worse? Y □ N □

What makes your problem worse?

What makes your problem better?

What normal life activities does your problem(s) interfere with:

Work □ Sleep □ Walking □ Sitting □ Hobbies □ Leisure □

YOUR HEALTH INFORMATION

Why This Form Is Important

As a full spectrum multidisciplinary office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Please, answer every question.

Growth and Development (To Age 17)

Research is showing that most of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	YES	NO	UNSURE
Did you suffer any other traumas?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	YES	NO	UNSURE
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree)	☐	☐	☐
As a child, were you under regular Chiropractic or physiotherapy care?	☐	☐	☐

Were you delivered: Naturally ☐ C-section ☐ Forceps ☐ Vacuum ☐ Mom induced ☐ Unsure ☐

Adult Years (Age 18 to present)

	YES	NO
Do/did you play contact sports?	☐	☐
Have you been in any accidents?	☐	☐
If so was your nerve system checked by a chiropractor or physio afterwards?	☐	☐
Have you had any surgery?	☐	☐

	YES	NO
Do/did you participate in extreme sports?	☐	☐
If so did you have your spine and nerve system checked regularly by a chiropractor or physiotherapist?	☐	☐

On a scale of 1-10 rate your stress level (1- none, 10-severe)

Occupational stress _____ Personal stress _____

For what? _____

Years of untreated damage typically shows up suddenly during unexpected times/activities and or eventually doesn't subside and becomes a chronic symptom. Please check **ALL** of the following symptoms you've had in the last **12 months,** even if they don't seem related to your current problem.

☐ Headaches	☐ Fatigue	☐ Sleeping Problems	☐ Cancer of _____
☐ Neck Pain	☐ Chronic Muscle Pain	☐ Constipation	☐ Loss of Balance
☐ Shoulder Pain	☐ Pins & Needles in Legs	☐ Knee Pain	☐ Double Vision
☐ Low Back Pain	☐ Pins & Needles in Arms	☐ lower leg pain	☐ Numbness in side of face or body
☐ Mid Back Pain	☐ Numbness in Fingers	☐ Ankle Pain	☐ Fainting
☐ Pain b/w shoulder blades	☐ Numbness in Toes	☐ Foot Pain	☐ Stroke
☐ Irritability	☐ Sciatica	☐ Heel Pain	☐ Heart disease or pacemaker
☐ Tension	☐ Hip Pain	☐ Flat Feet	☐ Other_____

OTHER than your chief complaint, what other health concerns you checked above would you want help with?

Choose your type of care

Our Office offers 3 types of care
Initial Intensive Care | Reconstructive Care |Wellness
To Better meet your Health Care Goals, Please check below (Check **ALL** that apply)

☐ I want to reduce or eliminate my symptoms
☐ I want my problem corrected & re-establish Health
☐ I want a BETTER Quality of life for me and my family
or
☐ I'm only interested in my health if insurance covers it.

Patient Signature:_____

Date:_____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have for your:

Children: _____
_____
Spouse: _____
_____
Mother/Father:_____
_____
Brother(s)/ Sister(s): _____
_____
Others: _____