Fergus Family Chiropractic Wellness Centre
370 St. Andrew St. W., Unit 1 Fergus, ON N1M 1N9 519-843-1500

CONFIDENTIAL PATIENT HEALTH RECORD

Name:			Date:	
Address:		City:	Postal Code:	
Home Phone: ( )	Work Phone: ( )	Date of Birth D M Y	Age:	Sex: □ Male □ Female
Cell Phone: ( )	Email address:	Extended Health Insurance? □ Yes □ No Details:		
Occupation:		Employer:		
Marital Status: □ Single □ Married □ Widowed □ Divorced □ Common-law		Spouse's Name:		
Do you have children? □ Yes □ No	What are their names/ages?			
Have you ever received chiropractic care before? □ Yes □ No If Yes, approximate date of your last visit: Doctor's name:				
Spinal x-rays taken in the last 12 months? □ Yes □ No Body Part(s):		Whom may we thank for referring you to our office?		

WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic 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.

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which can damage your health expression. With this case history, our goal is to uncover the layers of injury or damage (especially to your nervous system) that result in lowered health. Following your consultation, the doctor may recommend a specific course of examinations in order to determine whether you have spinal nerve stress causing interference with your inborn health potential.

LOSS OF WELLNESS

Research is showing that most of the health challenges that occur later in life have their origins during the developmental years, some starting from birth. Please complete the following questions as closely and carefully as possible.

Please check the appropriate answers:

Your birth process…

Was the delivery: □ Long and/or difficult (#of hours____) □ Forceps □ Vacuum extraction □ Caesarean □ Breech
Was your mother given: □ Drugs □ Epidural □ Induced-gel or Drip? Other complications? _____

Growth and Development…

Were you taught how to care for your spine?..... □ Yes □ No
Were you breast fed?..... □ Yes □ No How long? _____
Did you have (please circle): childhood falls—accidents—sports injuries—auto accidents—Other: _____

Current Health Habits…

Do you smoke?..... □ Yes □ No ____packs/week
Do you drink alcohol?..... □ Yes □ No ____beverages/week
Do you go to the dentist for regular check-ups? (min.yearly) ..... □ Yes □ No
Do you exercise regularly?..... □ Yes □ No
Do you belong to a gym or sports club?..... □ Yes □ No
Sleeping Posture: □ Side □ Stomach □ Back □ Restless # of pillows_____
How long do you sleep per night? Total ____ hrs. Sleep Quality (circle): Excellent Good Fair Poor
Rate your stress level on an average day (circle number):

1 2 3 4 5 6 7 8 9 10

Very Low Moderate Very High

SYMPTOMS AND ILL HEALTH (PRESENT STATE OF ILL HEALTH)

Years of uncorrected injury or damage show up as acute or chronic symptoms or health problems.

Main purpose for this appointment: _____
Have you tried anything to get rid of this problem? _____
At its worst, this problem interferes with: □ Your ability to work □ Hobbies/sports □ Family or social time
If you don't get this problem corrected, do you think it will get worse in the next 5-10 years? □ Yes □ No

Rate your level of commitment to getting this/these problem(s) corrected and improving your health?
(10 being the highest)

1 2 3 4 5 6 7 8 9 10

Very Low Moderate Very High

Please check any body signals that are or have caused you problems in the last *12-18 months*:

□ Neck pain/stiffness
□ Low back pain
□ Pain between shoulders
□ Pain or weakness (Circle below)
shoulders, arms, hands, fingers
buttocks, legs, feet, toes
□ Cold hands or feet
□ Arthritis/swollen joints/bursitis
□ Spinal curvature
□ Walking problems
□ Jaw problems
□ Loss of sleep
□ Fever
□ Indigestion/heartburn/ulcer
□ Black/bloody stools
□ Appetite changes/excessive thirst
□ Allergies
□ Ear infection/tonsillitis
□ Dizzy/light-headed/fainting
□ Hemorrhoids
□ Headaches/migraines
□ Numbness, tingling or weakness
□ Sinus problems
□ Convulsions/seizures
□ Nervousness/depression
□ Depression
□ Poor concentration/memory
□ Chest pain
□ High blood pressure (Low BP)
□ Stroke (T.I.A.)
□ Shortness of breath/cough
□ Heart problems
□ Fatigue/chronic tiredness
□ Nausea/vomiting
□ Excessive gas
□ Bloating
□ Sexual dysfunction
□ Infertility
□ Asthma
□ Constipation
□ Diarrhea (Irritable Bowel)
□ Weight change … gain/loss
□ Colitis
□ Liver/gall bladder trouble
□ Visual disturbance
□ Bronchitis/pneumonia
□ Deafness/hearing problems
□ Ears ringing (tinnitus)
□ Earaches
□ Blood sugar/diabetes
□ Sore throat (hoarseness)
□ Loss of smell/taste
□ Difficulty swallowing
□ Thyroid problems
□ Kidney problems/stones
□ Problems with urination
□ Increase frequency
□ Kidney/bladder/prostate
□ Frequent colds

Women Only:
□ Menstrual problems
□ Excessive cramps/pain
□ Irregular cycle
□ Menopause
□ Breast pain/lumps
□ Last menstrual period:
date: _____
Pregnant? □Yes □No □Unsure

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:

Spouse/Partner: _____
Children: _____
Mother/Father: _____
Brother(s)/Sister(s): _____
"The spine is the most overlooked and neglected part of a child's health." Do your children suffer from any of the following: (please circle): earaches, tonsillitis, headaches, allergies, frequent colds (3 or more/year), growing pains, asthma, bronchitis, bedwetting or other problems? _____

By signing here, I verify that the above information is true and accurate regarding my health history. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Signature: _____ Date: _____