Personal and Family Health History

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M F

Address: _____ City: _____

Province: _____ Postal Code: _____ Alberta Health #: _____

Phone: Home: _____ Cell: _____

Occupation: _____ Employer: _____

Email: _____ Marital Status: S M D W

Referred by: _____ Spouse Name: _____

Consent for Email Communication:

Email communication will be used in reference to your personalized treatment plan in the form of exercise prescriptions, newsletters, updates regarding clinic events/closures, and other wellness information that the doctor believes will be beneficial to your care. Your contact information will not be extended to other parties outside of the Divine Spine Chiropractic professionals and will not be used for the distribution of any materials not considered to be part of your treatment plan.

Initials: _____

Have you received previous chiropractic care? Y N

Do you have any children? Y N

Names: _____ _____ _____ _____

Ages: _____ _____ _____ _____

Have they received chiropractic care? Y N

Current Health Condition:

Present Complaint or Pain? If no current pain, what is the reason for your visit today?

Major _____

Pain or Problem started on _____

Pains are: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent

What activities aggravate your condition/pain?

_____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse? _____

Other Doctors seen for this condition: _____

Any home remedies? _____

Is this a work related injury? Y N Motor Vehicle injury? Y N Date of occurrence:_____

Other symptoms:

❒ Headaches	❒ Face Flushed	❒ Light Bothers Eyes	❒ Feet Cold
❒ Neck Pain	❒ Neck Stiff	❒ Loss of Memory	❒ Hands Cold
❒ Sleeping Problems	❒ Pins & Needles in Legs	❒ Ears Ring	❒ Diarrhea
❒ Back Pain	❒ Pins & Needles in Arms	❒ Fever	❒ Depression
❒ Nervousness	❒ Numbness in Fingers	❒ Fainting	❒ Fatigue
❒ Tension	❒ Numbness in Toes	❒ Cold Sweats	❒ Dizziness
❒ Irritability	❒ Shortness of Breath	❒ Loss of Smell	
❒ Chest Pains	❒ Loss of Balance	❒ Loss of Taste	
❒ Buzzing in Ear	❒ Constipation	❒ Stomach Upset	

If female, are you pregnant? Y N

Have you been under drug/medical care? _____ How long?_____

What medications are you taking? _____

Have you had surgery? Y N What?_____ When? _____

What side effects have you experienced from the drugs/surgery? _____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

What age did your oldest grandparents on record live to? _____ Still Living? Y N

As a result of your chiropractic care would you like to *(check all that apply)*

❒Get better quickly ❒Live a healthier lifestyle ❒Have a healthier spine and nervous system

Signature: _____ Date: _____