

Your potential for wellbeing lies within. Our purpose is to set it in motion.

Confidential Patient Health History

Date: _____

Sex: Male Female Other

Name: _____ Date of Birth: ____/____/____ Age: _____
MM DD YYYY

Address: _____ City: _____ Postal Code: _____

Phone: Home _____ Preferred Cell _____ Preferred

Employer: _____ Occupation: _____

Email: _____

Marital Status: S M D W Spouse's Name: _____

Number of children & ages: _____ Family Physician: _____

Have you ever received chiropractic care? Yes No

If yes, when and where? _____

Is this visit due to a motor vehicle accident? Yes No

If yes, date of accident _____

Referred by? _____

About Your Health

The human body is designed to be healthy. There are many events that occur and habits that we pick-up throughout our lifetime that may not allow us to maximize our optimum health potential. Please take a moment to fill out these questions so that we can better understand your overall health. We can then develop an appreciation for the layers of damage to your spine and nervous system that may be blocking your body's innate ability to be healthy.

*Welcome to Our Office
Dr. Greg Shaw
Dr. Steve Bako*

Events and Habits

NEONATAL TO ADULT: Many problems have their roots in early spinal and/or neurological damage.

Yes	No		Patient Comments
		1. YOUR BIRTH – answer to the best of your ability	
<input type="checkbox"/>	<input type="checkbox"/>	Was it a vaginal birth?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were forceps/vacuum extraction used?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mother given medication prior or during delivery?	_____
		2. GROWING YEARS	
<input type="checkbox"/>	<input type="checkbox"/>	Were you breast fed?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any significant childhood injuries or illnesses?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any childhood surgeries or prolonged medications?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you have any notable falls/injuries?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you play any sports? Competitive sports	_____
<input type="checkbox"/>	<input type="checkbox"/>	Subject of mental or physical abuse?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Any head injuries/broken bones?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you receive chiropractic care?	_____
		3. ADULTHOOD	
Physical Stresses			
<input type="checkbox"/>	<input type="checkbox"/>	Were you ever in a motor vehicle accident?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had any notable falls/injuries as an adult?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sports injuries/stresses?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you use proper body movement/lifting procedures?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Are you able to <u>sustain</u> proper posture?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Do you exercise regularly? <input type="checkbox"/> Daily <input type="checkbox"/> Weekends	<input type="checkbox"/> Sporadically
		Sleep posture <input type="checkbox"/> Side <input type="checkbox"/> Back	<input type="checkbox"/> Stomach
		During my day I mostly <input type="checkbox"/> Sit <input type="checkbox"/> Stand	<input type="checkbox"/> Walk
		<input type="checkbox"/> On the phone	<input type="checkbox"/> Drive car/truck
		<input type="checkbox"/> Other(please describe): _____	
Chemical Stresses			
<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	
<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcohol? <input type="checkbox"/> Daily <input type="checkbox"/> Weekends	<input type="checkbox"/> Sporadically
<input type="checkbox"/>	<input type="checkbox"/>	Do you eat as healthy as you think you should?	
<input type="checkbox"/>	<input type="checkbox"/>	Are you or have you ever been overweight?	
<input type="checkbox"/>	<input type="checkbox"/>	Are you exposed to chemicals or fumes?	
Mental/Emotional Stresses			
<input type="checkbox"/>	<input type="checkbox"/>	Occupational/work stress?	
<input type="checkbox"/>	<input type="checkbox"/>	Mental Stress?	

Symptoms and Ill Health

As the years go by and the layers of damage to your spine and nervous system increase, it is common to begin experiencing symptoms and have random bouts of ill health until we are brought to our present state of health.

Reason for consulting our office:

- Correction and prevention of existing problem?
- Maximizing personal and or family health potential?

What do you hope to gain from care at this office? _____

If you have a specific chief complaint, please describe briefly. If no, please proceed to next page.

How and when did this problem start? _____

Does the pain radiate or travel anywhere else? _____

- | | | | |
|----------------------------|--------------------------------------|---------------------------------------|--|
| Is the problem ... | <input type="checkbox"/> constant | <input type="checkbox"/> intermittent | <input type="checkbox"/> no change |
| Is the condition worse ... | <input type="checkbox"/> in the A.M. | <input type="checkbox"/> in the P.M. | <input type="checkbox"/> worse with movement |
| Is it interfering with ... | <input type="checkbox"/> sleep | <input type="checkbox"/> work | <input type="checkbox"/> daily routine |
| | <input type="checkbox"/> other _____ | | |
| Pain is... | <input type="checkbox"/> sharp | <input type="checkbox"/> dull | <input type="checkbox"/> throbbing |
| | <input type="checkbox"/> aching | <input type="checkbox"/> shooting | <input type="checkbox"/> nagging |
| | Other: _____ | | |

Is condition getting progressively worse? Yes No

How would you rate your pain on a scale of 1 – 10 (1=mild; 10=unbearable): _____

What aggravates your condition/pain? _____

What relieves your condition/pain? _____

Have X-rays, MRI or CAT been taken of the area? Yes No When? _____

Have you tried any of the following to solve the problem?

- | | | | |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> Ice | <input type="checkbox"/> Heat | <input type="checkbox"/> Stretching/exercise | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Rubs or gels | <input type="checkbox"/> Diet changes | <input type="checkbox"/> Stress reduction |
| <input type="checkbox"/> Aspirin or Tylenol | <input type="checkbox"/> Surgery | <input type="checkbox"/> Chiropractic care | <input type="checkbox"/> Massage/Body work |
| <input type="checkbox"/> Naturopathic care | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Other: _____ | |

Have you ever or do you presently suffer from any of the following symptoms?

Past	Now		Past	Now	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Ears ring
<input type="checkbox"/>	<input type="checkbox"/>	Blood pressure problem	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	Nose/sinus problems
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/balance issues
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/lung problems
<input type="checkbox"/>	<input type="checkbox"/>	Skin problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Tension
<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nausea
<input type="checkbox"/>	<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems
<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Digestive disorders	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems
<input type="checkbox"/>	<input type="checkbox"/>	Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or pins & needles in arms/legs
<input type="checkbox"/>	<input type="checkbox"/>	Cold feet/hands			
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis – Where? _____			

What medications or treatment you are receiving (include birth control pills)? Do you experience any side effects from these medications/treatment? Please describe.

List any surgeries and include when. Please describe any side effects you may have experienced.

Family history: (include parents, children & siblings)

Are your children experiencing any of the above listed symptoms? Yes No If yes, which ones?

	Heart Disease	Stroke	Cancer	Arthritis	Diabetes	Other _____
Father's Side	<input type="checkbox"/>					
Mother's Side	<input type="checkbox"/>					

*Chiropractic provides three types of care. The first is **Initial Intensive Care**, which corrects the most recent layer of Spinal and Neurological damage. This care usually reduces or eliminates the symptoms. Then **Corrective Care** begins, which corrects the years of damage that occurred when there were few symptoms. And finally, chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.*

I understand that the purpose of today's visit is to determine if I am a candidate for chiropractic care.

Patient's Signature: _____ (Guardian's Signature if under 16)