SHAW CHIROPRACTIC
FAMILY WELLNESS CENTRE

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

Confidential Patient Health History

Date: _____ Sex: ☐ Male ☐ Female

Name: _____ Date of Birth: ____/____/____ Age: _____
dd mm yy

Address: _____

Phone: Home_____ Cell_____ Work _____

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? _____

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, D.C

Dr. Greg Shaw, 586 Argus Rd, Oakville, Ontario L6J 3J3 905 842 5489 info@shawfamilywellness.com

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	_____
☐	☐	Was it a vaginal birth?	_____
☐	☐	Were forceps/vacuum extraction used?	_____
☐	☐	Mother given medication prior or during delivery?	_____
		2. GROWING YEARS	
☐	☐	Were you breast fed?	_____
☐	☐	Any significant childhood injuries or illnesses?	_____
☐	☐	Any childhood surgeries or prolonged medications?	_____
☐	☐	Did you have any notable falls/injuries?	_____
☐	☐	Did you play any sports? Competitive sports	_____
☐	☐	Subject of mental or physical abuse?	_____
☐	☐	Any head injuries/broken bones?	_____
☐	☐	Did you receive chiropractic care?	_____

3. ADULTHOOD

Physical Stresses

☐	☐	Were you ever in a motor vehicle accident?			_____
☐	☐	Have you had any notable falls/injuries as an adult?			_____
☐	☐	Sports injuries/stresses?			_____
☐	☐	Do you use proper body movement/lifting procedures?			_____
☐	☐	Are you able to <u>sustain</u> proper posture?			_____
☐	☐	Do you exercise regularly?	☐ Daily	☐ Weekends	☐ Sporadically
		Sleep posture	☐ Side	☐ Back	☐ Stomach
		During my day I mostly	☐ Sit	☐ Stand	☐ Walk
			☐ On the phone		☐ Drive car/truck
			☐ Other(please describe): _____		

Chemical Stresses

☐	☐	Do you smoke?			
☐	☐	Do you drink alcohol?	☐ Daily	☐ Weekends	☐ Sporadically
☐	☐	Do you eat as healthy as you think you should?			
☐	☐	Are you or have you ever been overweight?			
☐	☐	Are you exposed to chemicals or fumes?			

Mental/Emotional Stresses

☐	☐	Occupational/work stress?
☐	☐	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 ...	☐ constant	☐ intermittent	☐ no change
Is the condition worse ...	☐ in the A.M.	☐ in the P.M.	☐ worse with movement
Is it interfering with ...	☐ sleep	☐ work	☐ daily routine
	☐ other _____		
Pain is...	☐ sharp	☐ dull	☐ throbbing
	☐ aching	☐ shooting	☐ 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?

☐ Ice	☐ Heat	☐ Stretching/exercise	☐ Vitamins
☐ Medications	☐ Rubs or gels	☐ Diet changes	☐ Stress reduction
☐ Aspirin or Tylenol	☐ Surgery	☐ Chiropractic care	☐ Massage/Body work
☐ Naturopathic care	☐ Acupuncture	☐ Other: _____	

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

Past	Now		Past	Now	
☐	☐	Headaches	☐	☐	Ears ring
☐	☐	Blood pressure problem	☐	☐	Nervousness
☐	☐	Frequent colds	☐	☐	Nose/sinus problems
☐	☐	Fatigue	☐	☐	Dizziness/balance issues
☐	☐	Allergies	☐	☐	Asthma/lung problems
☐	☐	Skin problems	☐	☐	Fainting
☐	☐	Depression	☐	☐	Tension
☐	☐	Irritability	☐	☐	Frequent nausea
☐	☐	Chest pains	☐	☐	Heart problems
☐	☐	Sleep problems	☐	☐	Menstrual problems
☐	☐	Diarrhea	☐	☐	Constipation
☐	☐	Digestive disorders	☐	☐	Kidney problems
☐	☐	Bladder problems	☐	☐	Numbness or pins & needles in arms/legs
☐	☐	Cold feet/hands			
☐	☐	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	☐	☐	☐	☐	☐	
Mother's Side	☐	☐	☐	☐	☐	

*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)