EASTMOUNT CHIROPRACTIC & WELLNESS
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CONFIDENTIAL PATIENT HISTORY

Patient: _____

Dear Patient,

Please complete the following questionnaire. Your answers will help us determine if we can help you.
If we do not sincerely believe that your condition will respond satisfactorily, we will not accept your case.

PERSONAL INFORMATION

Name _____
Address _____ City _____ Postal Code _____
Home Phone _____ Cell/Work Phone _____
Email Address _____
Birth Date _____ Age _____ Occupation _____
Family Physician _____
How did you hear about our clinic? _____

HEALTH INFORMATION

Where is the location of your major complaint? _____
How did it start? _____
How long have you had this problem? _____
How severe is the pain? Mild? _____ Moderate? _____ Severe? _____
Is the problem: Getting better? _____ Getting worse? _____ Staying the same? _____
What makes the problem worse? _____
What makes it feel better? _____
Have you had any recent pain at night while you sleep? _____
Have you experienced any recent unexplained weight loss?_____
Do you participate in a regular exercise program?_____
Have you ever been in a serious motor vehicle accident? _____
Have you ever had a broken bone? _____ Please specify _____
Have you ever had any surgeries? _____ Please specify _____
Have you had any X-rays taken in the last 5 years? ____ Part of body? _____
If you smoke, how many cigarettes per day? _____
If you consume alcohol, how many drinks per week? _____
List any prescription and non-prescription medications that you are presently taking:
_____
Do you have any diagnosed medical conditions? (Eg. Diabetes, cancer, heart disease, etc.)
_____
Is there anything else you feel we should know about you or your condition?
_____
Have you ever been treated by a chiropractor or physiotherapist
_____

For Females Only:

How many pregnancies have you had? _____ How many deliveries have you had? _____

Are you currently pregnant? _____ How many weeks along? _____

Please CHECK any conditions that are PRESENTLY causing you a problem.

General Symptoms:
- ☐ Headache
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Loss of sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Loss of weight
- ☐ Numbness or pain in arms, hands, legs
- ☐ Allergy
- ☐ Wheezing
- ☐ Nerve pain

E.E.N.T.:
- ☐ Failing vision
- ☐ Glasses needed to see; Distances Read
- ☐ Crossed eyes
- ☐ Eye pain
- ☐ Deafness
- ☐ Earache
- ☐ Asthma
- ☐ Tooth decay
- ☐ Gum trouble
- ☐ Frequent colds
- ☐ Sinus infection
- ☐ Runny nose
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Cold sores
- ☐ Loss of hearing

Respiratory:
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Chest pain
- ☐ Difficult breathing

Cardiovascular:
- ☐ Rapid beating heart
- ☐ High blood pressure
- ☐ Pain over heart
- ☐ Stroke
- ☐ Hardening of arteries
- ☐ Varicose veins
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Angina

Muscles & Joints:
- ☐ Stiff neck
- ☐ Back ache
- ☐ Swollen joints
- ☐ Painful tailbone
- ☐ Foot trouble
- ☐ Shoulder pain
- ☐ Elbow pain
- ☐ Wrist pain
- ☐ Hand pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Arthritis

Skin:
- ☐ Rashes
- ☐ Itching
- ☐ Bruising easily
- ☐ Dryness
- ☐ Boils
- ☐ Hives (allergy)
- ☐ Hair loss

Genitourinary:
- ☐ Troubles urinating
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection
- ☐ Bed wetting
- ☐ Prostate trouble

G.U. for Women:
- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Cramps or back ache
- ☐ Vaginal discharge
- ☐ Swollen breasts
- ☐ Lumps in breasts

Gastrointestinal:
- ☐ Poor appetite
- ☐ Indigestion
- ☐ Excessive hunger
- ☐ Belching or gas
- ☐ Nausea
- ☐ Vomiting (blood?)
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids (piles)
- ☐ Jaundice
- ☐ Gall bladder trouble
- ☐ Intestinal worms
- ☐ Ulcer