Personal Health History

Name:_____ Referred by:_____

Address:_____ City:_____ Prov:_____

Postal Code:_____ Email:_____

Phone:(h)_____ (w)_____ (c)_____

Date of birth:_____ Occupation:_____

You deserve to be healthy. When you were conceived, you were given the blueprints, intelligence and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal and live the quality of life you deserve.

Circle all that apply:

1. Your birth

Long delivery	Difficult delivery	Forceps/vacuum	Caesarean
Breech	Home birth	Mother given drugs	Induced labor

Comments:_____

_____

2. Growth and development

Did you ever….

learn to care for your spine	fall out of bed	bang your head	have an accident
have a childhood illness	have surgery	take drugs	fall down the stairs
experience other trauma			

Comments:_____

_____

3. Current health habits

Did/do you….

smoke	drink	take drugs	diet	eat healthy foods
have teeth problems		eye problems	hearing problems	exercise regularly
have sleeping		problems physical stress/mental stress/ occupational stress		

Have you…. been in accidents had surgery had sports injuries

Sleep posture: side? back? stomach?

Comments:_____

_____

Current Health Condition

Major Complaint or Crisis? (what is the reason for your visit today?)

_____

When did the problem start?_____

Pains are: □sharp □dull □constant □intermittent □worsening

What activities aggravate your condition:_____

What activities lessen your condition:_____

Is condition worse at certain times of day (if so, when?):

_____

Is this condition interfering with: □work □sleep □routine □other_____

Other practitioners seen for this condition:_____

Other Symptoms

□headaches	□face flushed	□Light bothers eyes	□feet cold
□neck pain	□neck stiffness	□loss of memory	□hands cold
□sleeping problems	□pins and needles in legs	□ears ring	□upset stomach
□nervousness	□pins and needles in arms	□fever	□constipation
□tension	□numbness in toes	□fainting	□diarrhea
□irritability	□numbness in fingers	□cold sweats	□loss of balance
□chest pains	□shortness of breath	□loss of smell	□loss of taste
□dizziness	□fatigue	□depression	

Family History:	Heart disease	Arthritis	Cancer	Diabetes	Other
Father's side	□	□	□	□	_____
Mother's side	□	□	□	□	_____

Your oldest grandparent on record lived to the age of _____ □Still living □Deceased

As a result of my chiropractic care, I would like to (check all that apply):
□Feel better quickly □Have a healthier spine and nervous system □Live a healthier lifestyle

In order to determine the underlying cause of your complaint, Dr. Santin will perform a thorough assessment of your spine and nervous system at today's visit. This examination will consist of neurological and orthopedic tests, as well as an Insight Milennium scan (if warranted) including thermal, EMG and heart rate variability testing. At your next visit, Dr. Santin will discuss your findings, and you will decide on a mutually agreed upon plan of management.

I consent to a thorough spinal assessment with Dr. Santin.

_____ _____

Signature Date