Doctor:

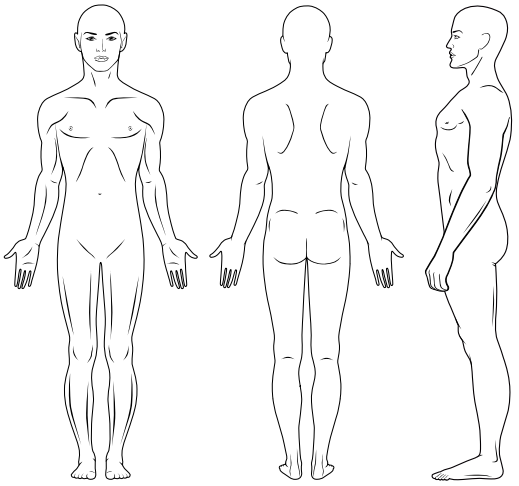
Patient:

Ottawa Health Group

Confidential Patient Case History

In the diagrams provided, please mark the areas of your body that you feel best represent the discomfort(s) or sensation(s) you are experiencing.
Use the symbols provided below.

Numbness:	/ / / /
Burning:	x x x
Dull and aching:	+ + +
Pins and needles:	* * *
Sharp and stabbing	= = =
Stiff and tight	2 2 2



GENERAL INFORMATION

Date: ☐ Miss ☐ Mrs. ☐ Ms. ☐ Mr. Name:

How would you like to be addressed? Date of birth: / / Gender: Age:
D M Y

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children: Names and Ages:

Address: City: Postal code:

Home phone: ( ) - Business phone: ( ) - Ext.:

Cellular/Other: ( ) - E-mail:

Occupation or profession: Employed by:

Name of medical doctor

EXTENDED COVERAGE? ☐ No ☐ Yes (Blue Cross, Great West Life, G.S.M.I.P.)

HEALTH ATTITUDES: Your attitude about your health is as important to us as the specific reason you've consulted our office. Below are four prevalent health attitudes. Please mark the one that most closely reflects your personal values.

☐ **Treatment Only:** I only consult a doctor when I have an ache or pain and discontinue care as soon as it has cleared up.

☐ **Prevention:** In addition to symptomatic treatment, I consult specialists occasionally to prevent problems from recurring.

☐ **Maintaining Health:** I'm conscious about my health, diet, exercise, etc. and actively pursue these, because I feel better and it maximizes my potential.

☐ **Family Health:** I take an active part in assisting, informing, and maintaining health, with my family, and I'm concerned with long term effects of good health.

What is your major complaint for which you are seeking treatment today?

Thank you. Again we look forward to a healthy relationship with you!

OFFICE USE ONLY:

Fee / Category: Referral source:

Previous chiropractic care? Yes No

Ottawa Health Group, 30 Edgewater St. Suite 121 Kanata, ON K2L 1V8 Tel: (613) 831-5554 Fax: (613) 831-6121 E-mail: wecarekanata@ottawahealthgroup.com

PRESENT HEALTH: Are you presently affected by any of the following? (within past three months)

0 = OCCASIONAL, F = FREQUENT, C = CONSTANT

MUSCLE AND JOINT	O	F	C
Backache	☐	☐	☐
Neck Pain	☐	☐	☐
Painful tailbone	☐	☐	☐
Foot trouble	☐	☐	☐
Shoulder pain	☐	☐	☐
Hernia	☐	☐	☐
Spinal curvature	☐	☐	☐
Faulty posture	☐	☐	☐
Arthritis	☐	☐	☐

STRESS SYMPTOMS	O	F	C
Headache/Migraine	☐	☐	☐
Dizziness	☐	☐	☐
Numbness or pins & needles in arms/hands, legs/feet	☐	☐	☐
Ringing in ears	☐	☐	☐
Blurring of vision	☐	☐	☐
Loss of sleep	☐	☐	☐
Loss of concentration/memory	☐	☐	☐
Irritable/Nervousness	☐	☐	☐
Depression	☐	☐	☐
Decreased energy/fatigue	☐	☐	☐
Tension	☐	☐	☐

GENERAL SYMPTOMS	O	F	C
Fever/Chills/Sweat	☐	☐	☐
Fainting	☐	☐	☐
Convulsions	☐	☐	☐
Allergy	☐	☐	☐
Skin problems	☐	☐	☐
Colds	☐	☐	☐
Tremors	☐	☐	☐
Loss of balance	☐	☐	☐

RESPIRATORY	O	F	C
Chronic cough	☐	☐	☐
Spitting up phlegm/blood	☐	☐	☐
Chest pain	☐	☐	☐
Difficult breathing	☐	☐	☐

URINARY	O	F	C
Painful urination	☐	☐	☐
Getting up at night to urinate	☐	☐	☐
Blood in urine	☐	☐	☐
Increased urination	Yes ☐	No ☐	

GASTROINTESTINAL	O	F	C
Difficult digestion	☐	☐	☐
Belching or gas	☐	☐	☐
Nausea or vomiting	☐	☐	☐
Pain over stomach	☐	☐	☐
Constipation	☐	☐	☐
Colon trouble	☐	☐	☐
Liver trouble	☐	☐	☐
Gall bladder trouble	☐	☐	☐
Heartburn	☐	☐	☐
Diarrhea	☐	☐	☐
Bloody stools	☐	☐	☐

EYES, EARS, NOSE, THROAT	O	F	C
Deafness	☐	☐	☐
Earache	☐	☐	☐
Sore throat	☐	☐	☐
Asthma	☐	☐	☐
Tonsillitis	☐	☐	☐
Sinus trouble	☐	☐	☐

CARDIOVASCULAR	O	F	C
Rapid heart beat	☐	☐	☐
Slow heart beat	☐	☐	☐
High blood pressure	☐	☐	☐
Low blood pressure	☐	☐	☐
Pain over heart	☐	☐	☐
Swelling of ankles	☐	☐	☐
Previous heart attack	Yes ☐	No ☐	
Poor circulation	Yes ☐	No ☐	
Previous stroke	Yes ☐	No ☐	

FEMALES ONLY

Painful menstruation	Yes ☐	No ☐
Excessive flow	Yes ☐	No ☐
Irregular	Yes ☐	No ☐
Cramps or backache	Yes ☐	No ☐
Abnormal discharge	Yes ☐	No ☐
Passed menopause	Yes ☐	No ☐
Birth control pill	Yes ☐	No ☐
Number of miscarriages	_____	
Are you pregnant?	Yes ☐	No ☐

Date of last menstruation (period)?

_____

PAST HEALTH: Have you ever suffered from any of the following conditions?

Thyroid trouble	Yes ☐ No ☐	Tuberculosis	Yes ☐ No ☐	Emotional problems	Yes ☐ No ☐	Psoriasis	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Pneumonia	Yes ☐ No ☐	Epileptic seizures	Yes ☐ No ☐	Polio	Yes ☐ No ☐
High blood pressure	Yes ☐ No ☐	Back pain	Yes ☐ No ☐	Asthma	Yes ☐ No ☐	Cancer	Yes ☐ No ☐
Heart disease	Yes ☐ No ☐	Headaches	Yes ☐ No ☐	Arthritis	Yes ☐ No ☐	Venereal disease	Yes ☐ No ☐
Allergies	Yes ☐ No ☐	Stomach ulcers	Yes ☐ No ☐	Alcoholism	Yes ☐ No ☐	HIV	Yes ☐ No ☐

Please list any significant illness, operations, accidents, falls, or traumas:

Date	Illness / Operation / Accident / Falls	Medications / Vitamins / Supplements

Informed Consent to Examination and X-RAY:

I, as a patient, or guardian with no limited access, consent to the performance of a Orthopedic and Neurological examination. I understand that there is a very low risk of injury or aggravation from the examination procedures. These risks may include muscle strains and sprains, rib fractures, disc injuries and strokes.

Print patient name _____ Name of guardian (if applicable) _____ Patient Signature/Guardian _____ Date _____

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