Doctor:

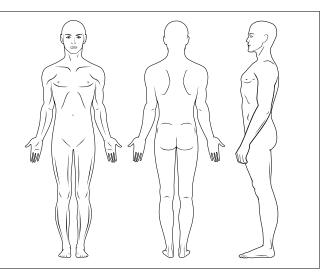
Patient:



# **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:	ххх
Dull and aching:	+ + +
Pins and needles:	* * *
Sharp and stabbing	= = =
Stiff and tight	222



### **GENERAL INFORMATION**

Date:	□ Miss □ Mrs. □ Ms. □ Mr.	Name:	
How would you like to be addressed?	Date of birth:	/ / D M Y	Age: Gender:
Marital status: Single Married Divorced Wid	owed Number of children:	Names and Ages:	
Address:	City:	Postal code:	
Home phone: ( ) -	Business phone: ( )	-	Ext.:
Cellular/Other: ( ) -	E-mail:		
Preferred phone number:	Occupation or profession:		
Employed by:			
Name of medical doctor			

### EXTENDED COVERAGE? IN O 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, 81 Metcalfe St. Suite 1100 Ottawa, ON K1P 6K7 Tel: (613) 564-9000 Fax: (613) 564-0917 E-mail: wecare@ottawahealthgroup.com

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

EYES, EARS,

NOSE, THROAT

0 = OCCASIONAL, F = FREQUENT, C = CONSTANT

MUSCLE AND JOINT	OFC	GENERAL SYMPTOMS	OFC
Backache		Fever/Chills/Sweat	
Neck Pain		Fainting	
Painful tailbone		Convulsions	
Foot trouble		Allergy	
Shoulder pain		Skin problems	
Hernia		Colds	
Spinal curvature		Tremors	
Faulty posture		Loss of balance	
Arthritis			
		RESPIRATORY	OFC
STRESS SYMPTOMS	OFC	Chronic cough	
Headache/Migraine		Spitting up phlegm/blood	
Dizziness		Chest pain	
Numbness or pins & needles		Difficult breathing	
in arms/hands, legs/feet			
Ringing in ears		URINARY	OFC
Blurring of vision			••••
Loss of sleep		Painful urination	
Loss of concentration/memory		Getting up at night to urinate	
Irritable/Nervousness		Blood in urine	
Depression		Increased urination Yes	
Decreased energy/fatigue			
Tension			

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

Deafness

Earache

Sore throat

Asthma

Tonsillitis

Sinus trouble

CARDIOVASCULAR	OFC
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

OFC

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

Patient Signature/Guardian