Doctor:	
Patient # Downtown:_	/Kanata



Confidential Patient Case History

Fee / Category:

Previous chiropractic care?

Yes

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: 1111 Burning: X X XDull and aching: +++ Pins and needles: Sharp and stabbing === Stiff and tight 222 **GENERAL INFORMATION** Children: ☐ Yes ☐ No Date: __ <u>Name:</u> How would you like to be addressed? Date of birth: City: Postal code: Business phone: (Ext.: Home phone: (- ___ E-mail: Occupation or profession: Preferred phone number: Employed by: Name of medical doctor: OHIP# What is your major complaint for which you are seeking treatment today? EXTENDED COVERAGE: Many of the services offered at the Ottawa Health Group are covered under your Extended Health Benefits. Some insurance providers require a referral from your medical doctor for you to be reimbursed. For information relating to your specific coverage please contact your individual provider. **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. Thank you. We look forward to a healthy relationship with you! OFFICE USE ONLY:

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

0 = OCCASIONAL, F = FREQUENT, C = CONSTANT - Please leave blank if not applicable.

MUSCLE AND JOINT	OFC	GENERAL SYM	PTOMS OFC	GASTROINTESTINAL	LOFC	CARDIOVASCULAR	OFC
Backache		Fever/Chills/Sweat		Difficult digestion		Rapid heart beat	
Neck Pain				Belching or gas		Slow heart beat	
Painful tailbone				Nausea or vomiting		High blood pressure	
Foot trouble				Pain over stomach		Low blood pressure	
Shoulder pain				Constipation		Pain over heart	
Hernia				Colon trouble		Swelling of ankles	
Spinal curvature				Liver trouble		Previous heart attack	Yes □ No □
Faulty posture		Loss of balance		Gall bladder trouble		Poor circulation	Yes □ No □
Arthritis				Heartburn		Previous stroke	Yes □ No □
		RESPIRATORY	OFC	Diarrhea			
STRESS SYMPTOMS	OFC			Bloody stools		IF APPLICABLE	
		_				_	v
Headache/Migraine			blood	EYES, EARS,		Painful menstruation	
Dizziness				NOSE, THROAT	OFC	Excessive flow	
Numbness or pins & needle in arms/hands, legs/feet		Difficult breathing				Irregular	
Ringing in ears				Deafness		Cramps or backache	
		URINARY	OFC	Earache		Abnormal discharge	
Blurring of vision		Painful urination		Sore throat		Passed menopause	
Loss of sleep			o urinate	Asthma		Birth control pill	Yes □ No □
Loss of concentration/memo		Blood in urine		Tonsillitis		Number of miscarriages	
Irritable/Nervousness			Yes □ No □	Sinus trouble		Are you pregnant?	Yes ☐ No ☐
Depression		increased dimation	ies in ind in			Date of last menstruation	n (period)?
Decreased energy/fatigue							
Tension							
Thyroid trouble			Yes□ No□ Yes□ No□	Emotional problems Epileptic seizures		Psoriasis Polio	
Diabetes \\ High blood pressure \\				Asthma			
			Yes No			Cancer	
Heart disease			Yes □ No □	Arthritis		Venereal disease	
Allergies	′es ⊔ No ⊔	Stomach ulcers	Yes ☐ No ☐	Alcoholism	Yes ⊔ No ⊔	HIV	Yes □ No □
Please list any signi	ficant illness	•	cidents, falls, or tra		Medica	itions / Vitamins / Supp	ulaments
Date			illiness / Operation /	Accident/ I alis	Wedica	uloris / Vitarrillis / Supp	iements
Informed Cons	ent to Exa	amination:					
				nce of a Orthopedic and hese risks may include			
Print patient name		— Name of gua	rdian (if applicable)	Patient Signatu	ıre/Guardian	 Date	