CONFIDENTIAL PATIENT HEALTH PROFILE

Today's Date: ___________________________

Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask.

PERSONAL INFORMATION

Name: Mr. Mrs. Ms Miss Dr. ____
Marital Status: M S W D **Alberta Health Care Number:** ____________________
Address: ____ **City:** ________________
Postal Code: ______________ **Home #:** ________________ **Cell/Business #**______________
Date of Birth: dd_____mm_____yy_______ **Age:** _____ **Gender:** M F OTHER
Email address (for appointment reminders): ______________________
Employer: ________________________ **Occupation:** ______________________________
Hobbies (what occupies your spare time?)____
Emergency Contact name and # ____
Children (#) __________
How did you hear about our office or whom may we thank for referring you?
____

HEALTH INFORMATION

Is this injury work related? □ **Yes** □ **No**
What is your major complaint?
____
How long have you had this condition?
____
Have you had this or similar conditions in the past? ☐ No ☐ Yes, **When?**
____
What activities aggravate your condition?
____
What makes it better?
____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐Constant ☐ Intermittent
If you are experiencing pain, how would you describe it? (Dull, sharp, shooting etc.)
____
Is this condition interfering with your ☐Work ☐ Sleep ☐ Daily Routine ☐Other ____________
On a scale of 1 to 10, rate your stress levels. (0 = none, 10 = extreme)
Occupational _______ **Personal** ________
How long has it been since you really felt well? ______________________________
Has there been a medical diagnosis of your complaint? ☐ Yes ☐ No **If "yes", list the Doctor's name and the diagnosis:** ____

Please check all that apply to your current/past medical history:

____ Neck Pain/stiffness
____ Mid Back Pains
____ Low Back Pain
____ Pins/Needles in Arms
____ Numbness in Fingers
____ Pins/Needles in Legs
____ Numbness Legs/Toes
____ Headaches
____ Fatigue
____ Weakness
____ Insomnia
____ Fever
____ Arthritis (RA, OA)
____ Weight Change
____ Skin Rashes
____ Bruise Easily
____ Dizziness
____ Fainting
____ Seizures

____ Vision Trouble
____ Nose Bleeds
____ Sinus Problems
____ Ringing in Ears
____ Hearing Trouble
____ Sore Throat
____ Throat Infection
____ Asthma
____ Chest Pain
____ Heart Palpitations
____ Heart Murmur
____ Varicosities
____ Swollen Extremities
____ Blue Extremities
____ Breast Pain
____ Lumps in Breast
____ Breast Discharge
____ Abdominal Pain
____ Decreased Appetite

____ Increased Appetite
____ Excess Gas
____ Vomiting
____ Diarrhea
____ Constipation
____ Hemorrhoids
____ Painful urination
____ Frequent Urination
____ Bedwetting
____ Prostate Problems
____ Impotence
____ Painful Menstruation
____ Sterility
____ Menopause
____ Anxiety
____ Depression
____ Memory Loss
____ Mood Swings
____ Other…

List surgeries, broken bones, and major illnesses (including childhood): ______________________________
____
____

Have you ever been hospitalized? ☐ Yes ☐ No **Reason:** ______________________________

How healthy is your family? Are there any conditions like diabetes, cancer or heart disease on your mother or father's side? If so explain: ______________________________
____

Have you ever been in an auto accident?
☐ Never ☐ Past Year ☐ Past 5 Years ☐ Over 5 Years

Is there or might there be a lawyer involved? ☐ Yes ☐ No

Description of accident:
____
____
____

Date of most recent physical examination? ______________________________

LIFESTYLE HABITS

Do you smoke: ☐ Yes ☐ No **How much?** ______________________________

Alcohol Consumption? ☐ Yes ☐ No **How many drinks per week?** ______________________________

Are you a coffee drinker? ☐ Yes ☐ No **How many cups a day?** ______________________________

Are you a soda drinker? ☐ Yes ☐ No **How many cans a day?** ______________________________

How many glasses of water do you drink per day? ☐ 0-4 ☐ 4-8 ☐ 8-12 ☐ 12+

Do you sleep well? Rate your sleep from 1 – 10 _________ (10 being the best sleep possible)

How many hours on average do you get in a night? ☐ 4-6 ☐ 6-8 ☐ 8-10 ☐ 12+

How do you sleep? ☐ Stomach ☐ Side ☐ Back

Do you eat a healthy diet? ☐ Yes ☐ No

List any prescription drugs, over the counter medications, vitamins, and natural supplements you are taking: ____

Have you ever been to a chiropractor before? ☐ Yes ☐ No

Doctor's Name/Location ______________________ **When was your last visit?** ______________

Reason for visit? ____

Were X-rays taken? ______________________ **Date Taken**: ______________________

Have you consulted other healthcare providers for this condition? (RMT's, Physio, Accupuncture, MD, ND etc): ____

____

Please draw the location of your pain or discomfort on the images below. Use the symbols to represent the type(s) of pain:

D = Dull	**S = Sharp / Stabbing**
B = Burning	**T = Tingling (Pins and Needles)**
N = Numb	**C = Cramping**