Oswell Chiropractic Centre

420 Talbot St. W., Aylmer, Ontario N5H 1K9 519-765-2565

Confidential Chiropractic Patient History

Name: Date:

Address City P.C.

Home Phone: Cell: Work

Date of Birth: day- month- year- email:

Physician:

Referred by:

Occupation: Employer:

Have you ever received Chiropractic Care? Yes No If 'yes'-date of last adjustment

About Your Care

*Chiropractic provides three types of care. The first is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological damage (Vertebral Subluxation Complex- VSC). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care,** which corrects the years of damage that occurred when there were few symptoms. Finally, Chiropractic offers a genuine approach to **Wellness Care**. All of these options will be explained at you report of findings. Then you will be able to begin a course of care that fits your health goals.*

About your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system. Then we will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Indicate Y-yes, N-no, or circle appropriate response. Give details if necessary.

Your Birth Process

Was the delivery long? Was the delivery difficult? Cord around neck?

Forceps? Caesarean? Vacuum Extraction? Breach/cephalic?

Home or Hospital birth? Labour induced?

Mother given drugs during delivery?Epidural?

Was the baby premature? If yes, what was his/her age and weight?

Growth and Development

Were you taught to care for your spine? Did you roll out of bed?

Were you breast fed? Childhood sicknesses?

Did you fall while learning to walk? Yanked by your arm?

Fall down stairs? Other traumas? What?

When?

Age 5- Present

Were you taught proper body movement and care?

Did/do you smoke? Did/do you drink alcohol?

Diet-do you eat healty foods? Exercise regularly?

Sleeping habits (nightmares)? Sleeping posture? Side Stomach Back Mattress type

On a scale of 1-10 describe your stress level [0-none, ten- severe] occupational, physical, emotional

Physical stress? Mental/ emotional stress?

Occupational stress?

Hobbies/ sports injuries?

Have you been in accidents (Auto or other)

Other traumas or problems?

Symptoms and Present Major Complaint and History of Condition

Pain or problem started (date) Is condition getting worse?

Pains are: Sharp Dull Constant Intermittent/ Comes & goes Travels

What activities aggravate your condition/pain?

What activities lessen your condition/pain?

Is condition worse during certain times of the day?

Does condition interfere with: Work? Sleep? Daily Routine? Walking Sitting Hobbies

How long has it been since you have felt really well?

Are you presently under care for this problem?

What medications are you taking?

Have you had surgery? What? When?

Other symptoms?

Please check the appropriate symptoms which you now have or have had previously. We want all the facts about your whole health picture.

Muscle & Joint

- ☐ Low back pain/Lumbago
- ☐ Neck pain/ stiffness
- ☐ Pain between the shoulders

Pain or numbness in:

- ☐ Shoulders
- ☐ Arms
- ☐ Elbows
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Arthritis
- ☐ Bursitis
- ☐ Jaw
- ☐ Foot trouble
- ☐ General stiffness
- ☐ Hernia
- ☐ Painful tailbone
- ☐ Poor posture
- ☐ Sciatica
- ☐ Spinal curvature
- ☐ Swollen joints

General

- ☐ Allergy
- ☐ Chills
- ☐ Confusion
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness/depression
- ☐ Neuralgia
- ☐ Numbness/tingling
- ☐ Sweats
- ☐ Tremors

Cardio-vascular

- ☐ Stroke or stroke-like occurrence
- ☐ Hardening of arteries
- ☐ High blood pressure
- ☐ Low blood pressure

Gastro- Intestinal

- ☐ Belching of gas
- ☐ Colitis
- ☐ Colon trouble
- ☐ constipation
- ☐ Diarrhea
- ☐ Difficult digestion

- ☐ Distension of abdomen
- ☐ Excessive hunger
- ☐ Gall bladder trouble
- ☐ Haemorrhoids
- ☐ Intestinal worms
- ☐ Jaundice
- ☐ Liver trouble
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting
- ☐ Vomiting of blood

Eyes, Ears, Nose & Throat

- ☐ Asthma
- ☐ Colds
- ☐ Crossed eyes
- ☐ Deafness
- ☐ Dental decay
- ☐ Earache
- ☐ Ear discharge
- ☐ Ear noises
- ☐ Enlarged glands
- ☐ Enlarged thyroid
- ☐ Eye pain
- ☐ Failing vision
- ☐ Far sightedness
- ☐ Gum trouble
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Nasal obstruction
- ☐ Near sightedness
- ☐ Nosebleeds
- ☐ sinus infection
- ☐ sore throat tonsillitis

Respiratory

- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficult breathing
- ☐ Spitting of blood
- ☐ Spitting up phlegm
- ☐ Wheezing

Skin

- ☐ Boils
- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives/allergy
- ☐ Itching
- ☐ Skin eruptions (rash)
- ☐ Varicose veins

- ☐ Genito-urinary
- ☐ Bed-wetting
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Inability to control kidneys
- ☐ Kidney infection or stones
- ☐ Painful urination
- ☐ Prostate trouble
- ☐ Pus in urine

For women only

- ☐ Congested breasts
- ☐ Cramps or backache
- ☐ Excessive menstrual flow
- ☐ Hot flashes
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ Painful menstruation
- ☐ Vaginal discharge
- ☐ Are you pregnant?

Conditions you have/had

- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Cancer
- ☐ Chorea
- ☐ Cold sores
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

Anyone in your family had any of the following diseases

- ☐ nervous disorder
- ☐ heart disease
- ☐ cancer
- ☐ diabetes
- ☐ allergies
- ☐ gout
- ☐ tuberculosis
- ☐ rheumatoid arthritis
- ☐ hypertension
- ☐ other arthritis

ACCIDENT/ INJURY INFORMATION: ie recent motor vehicle accident (MVA) or workplace injury (WSIB)

(fill in only if it applies to you)

Accident/ injury occurrence date _____ Reported to Insurance/workplace [date] _____

Did you require post-accident hospitalization? Yes No Xrays? CAT scan? MRI?

Have you lost days at work? If 'yes' dates: _____

How did accident/injury occur? _____

I hereby declare that all statements and answers made in this form are to the best of my knowledge true and complete and that this information will be treated as confidential.

Signature:_____ **Date:**_____