Northern Hills Chiropractic & Wellness Centre

Name: ____ Date: ____________________

Address: ____ Postal code: ______________

City:____ Province: _________________

Telephone: Home___________________ Work_______________ Cell ________________

Email Address: ____

Date of Birth (M/D/Y): ______________ Age: _______ Weight: _____ Height: _______

Alberta Health Care number: _____________________ Gender: M/F

Occupation: ___________________________________ Employer: __________________

Employer/ School Address: ____

Marital Status: Single Married Divorced Separated Widow Cohabiting

Women: Are you pregnant? Yes No

Nursing? Yes No

Taking birth control pills? Yes No

How did you find out about Ascension Wellness Centre? ___________________________

Who referred you to Ascension Wellness Centre? _________________________________

Is this a medical legal case? If so, name of lawyer? _________________________________

Did the injury happen at work? Yes No

Client Health Information

Present area of concern (where & specifically):

____

Your symptoms are (circle): increasing not changing decreasing

Have you had any previous treatment for this condition? Yes No

When did you first notice symptoms? ____

What makes your problem better? ____

Which activities are difficult to perform? Sitting Standing Walking Bending

Laying Down Other: ______________________________________

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps

Stiffness Swelling Other:____

Rate the severity of your pain. (0, no pain to 10, worst pain imaginable) 0 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does is come and go? ____

What makes your problem worse? ____

What is the purpose of this appointment? ____

What type of care you desire (circle)? [Acute] [Temporary relief] [Corrective care]

[Preventative care/ Wellness]

Name of family physician: ____

Names of specialists currently consulting: ____

List all medications you are presently taking? ____

List all supplements/vitamins you are presently taking? ____

List any allergies: ____

Please circle any of these professionals you have seen previously and the approx date of your last visit?
Chiropractor: ____________ Acupuncturist: _____________ Massage therapist: ____________
Have you been treated for any health condition in the last year? Yes No
If so, please explain: ____
List all major surgeries or operations and when they occurred:
____
List any Major Accidents or falls:
____

Please circle any conditions which are **presently causing you any problems**
Please underline any that have bothered you in the past.

General
Whiplash Enlarged glands Loss of weight Hypoglycemia Fertility Problems
Vision problems Hearing problems Frequent colds/flu Menopause

Body Systems
Frequent urination Painful urination Blood in urine Kidney stones Prostate problems
Anemia Hypothyroid Hyperthyroid Gas/Bloating Constipation
Diarrhea Colitis Hemorrhoids Liver trouble Asthma Eczema
Psoriasis Varicose veins
Shortness of breath Heart problems Black/bloody stool Gall bladder trouble

Musculoskeletal System
Low back pain Neck pain Arm pain Shoulder pain Elbow pain Wrist pain
Leg pain Knee pain Foot pain Clicking jaw Walking problems
Ankle swelling Scoliosis Arthritis Pain/numbness down arms or legs Painful tailbone
Pain between the shoulders Difficulty chewing

Nervous System
Vertigo Dizziness Fainting Headaches Ringing in the Ears
Confusion Depression Loss of feeling

Circle any that you have experienced:
Alcoholism Epilepsy Stroke Arthritis Hypoglycemia Tuberculosis Cancer Allergies Diabetes
Rheumatic fever Heart disease Osteoporosis High blood pressure / Low blood pressure

Has anyone in your family had any of the following?
Heart disease Cancer High blood pressure Stroke Arthritis Diabetes

How many times per week do you exercise? ______________________________________
How many hours of sleep do you get per night? Do you feel it is enough? ______________
How much coffee do you drink? ____________ How much tea do you drink? ___________
How much alcohol do you consume (circle)? None Light Moderate Heavy
How much tobacco do you consume (circle)? None Light Moderate Heavy
How stressed are you (circle)? None Light Moderate Heavy
What are your health goals? ____
How many glasses of water do you drink per day? ____________

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Acupuncture Health Information Sheet

Name:____ Date: ______________

Do you have any of the following? Please check the applicable boxes:

AIDS ( ) Arthritis ( ) Asthma ( ) Cancer ( )
Depression ( ) Diabetes ( ) Stroke ( ) Heart Disease ( )
Kidney Disease ( ) Pace Maker ( ) Epilepsy/Seizures ( ) Thyroid Dysfunction ( )
Hepatitis ( ) Metal Implants ( ) High Blood Pressure ( )

Current history

What brings you in for an Acupuncture & Chinese Medicine?

Have you consulted a medical doctor about the condition for which you seek Traditional Chinese Medicine treatment? Yes____, No____
Have you received any treatment in other clinic (include Acupuncture & Herbs)?
Yes____, No____
If yes, describe what type treatment and medication you have been given (when, where, how long, name of medication, dosage; etc.)

Do you bleed or bruise easily? Y___, N___
Are you on anti-coagulant medication? Y___, N___
Allergies: Y___, N___ Type____
Pain: Are you experiencing any pain now? Y___, N___ Where_____________________
How would you rate your pain from a scale of 0 (least) to 10 (lots)? Score_____________
Sensation: ( ) Numbness: where___________ ( ) Tingling: where__________________
( ) Dizziness: how often________________ when______________________

Energy level:

Your energy in general: ( ) normal, ( ) decreased
Concentration/memory: ( ) normal, ( ) decreased
Do you feel tired? ( ) Always, ( ) Sometimes

Do you experience or have you experienced any of the following in the past months?

Shortness of breath Y__ N__; Palpitations Y__ N__; Pain or tightness in chest Y__ N__;
Swelling Y__ N__, where___________ ; Skin problems Y__ N__, Describe__________