INNER WISDOM
CONFIDENTIAL PATIENT HEALTH HISTORY

Dr. J. Randall, B.Sc., DC

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Name: _____ Birth Date: M_____D____YR_____ Age: _____ Sex: M □ F □

Address: _____ City: _____ Postal Code: _____

Marital Status: Married Single Common Law Number of Children: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____ Extension: _____

E-mail: _____ Employer: _____ Type of Work: _____

Medical Doctor's Name and Phone Number: _____

Have you had previous Chiropractic Care? □ None □ DC's Name and last visit:_____

Do you have extended health care insurance (Benefits, Group Insurance)? □ No □ Yes Amount of Coverage _____

Who may we thank for referring you to our office? _____

YOUR HEALTH PROFILE

As a full service wellness office, our focus is on your ability to achieve optimal health. Our goals are to address the issues that brought you to this office, as well as offering you the opportunity to explore improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential.

If you have no symptoms or complaints presently, and are here for wellness services, (√) check here _____ and skip to Past Health Profile. Those with symptoms or complaints need to briefly describe the chief area of complaint.

What is the purpose of this appointment? _____

Other practitioners seen for this condition? □ No □ Yes Who and When? _____

When did this condition begin? _____ Has it occurred before? □ No □ Yes When? _____

Is the condition: □ Job Related □ Auto Accident □ Home Injury □ Fall □ Other _____

Date of Accident: _____ (supplemental forms required for motor vehicle and work accidents)

What aggravates your condition? _____ What relieves your condition? _____

Is your condition: □ Becoming Worse □ Constant □ Comes and Goes □ Improving

Character of Pain: □ Sharp □ Dull □ Ache □ Pins & Needles □ Numb □ Burning □ Travels to _____

Does your condition interfere with: □ Work □ Sleep □ Hobbies/Sports □ Happiness/Quality of life

Do you currently take any medications or supplements? Please List: _____

_____

Have you had Spinal X-Rays taken in the last 12 months? □ No □ Yes Where? _____

PAST HEALTH PROFILE

Below is a list of symptoms or illnesses which may seem unrelated to the purpose of your appointment, however, these questions must be answered carefully, as these conditions may affect your overall course of chiropractic care. Check any of the following you experience currently, or have had in the recent (6 months) past:

- ☐ neck pain
- ☐ chewing/jaw problems
- ☐ hearing loss
- ☐ stuffed nose
- ☐ dental problems
- ☐ arm pain
- ☐ fatigue
- ☐ loss of sleep
- ☐ allergies
- ☐ headaches
- ☐ vision problems
- ☐ convulsions/seizures
- ☐ dizziness
- ☐ depression
- ☐ fainting
- ☐ forgetfulness
- ☐ stress
- ☐ walking problems
- ☐ nervousness
- ☐ numbness
- ☐ paralysis
- ☐ tingling extremities
- ☐ joint pain/stiffness
- ☐ fever
- ☐ sore throat
- ☐ ear aches/infections
- ☐ recurrent colds/flus
- ☐ pain between shoulders
- ☐ low back pain
- ☐ chest pain
- ☐ shortness of breath
- ☐ blood pressure problems
- ☐ irregular heart beat
- ☐ heart problems
- ☐ lung congestion
- ☐ varicose veins
- ☐ ankle swelling/edema
- ☐ stroke
- ☐ bladder trouble
- ☐ sexual dysfunction
- ☐ menstrual irregularity
- ☐ vaginal pain/infection
- ☐ breast pain/lumps
- ☐ prostate dysfunction
- ☐ discoloured urine
- ☐ excessive thirst
- ☐ painful/excessive urine
- ☐ poor/excessive appetite
- ☐ frequent nausea
- ☐ vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ liver problems
- ☐ gall bladder problems
- ☐ weight trouble
- ☐ abdominal cramps
- ☐ heartburn
- ☐ black/bloody stool
- ☐ colitis

FEMALES ONLY:

When was your last period? _____
Are you pregnant? ☐ Yes ☐ No ☐ Unsure

STRESS INDEX

Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential. Research is showing that many of the health challenges that occur in later life have their origins during the developmental years, some starting at birth. Please answer to the best of your ability:

Growing Years:

Were you breast-fed? How long? _____	☐ Yes ☐ No	_____
Were you vaccinated?	☐ Yes ☐ No	_____
Any notable falls (out of crib/change table, etc)?	☐ Yes ☐ No	_____
Any hobby or sports injuries?	☐ Yes ☐ No	_____
Any significant childhood illnesses?	☐ Yes ☐ No	_____
Were you ever hospitalized?	☐ Yes ☐ No	_____
Any childhood surgeries or prolonged medications?	☐ Yes ☐ No	_____
Ever assessed/fitted for orthotics?	☐ Yes ☐ No	_____
Any mental or physical abuse?	☐ Yes ☐ No	_____
Ever involved in a motor vehicle accident?	☐ Yes ☐ No	_____

Adulthood:

Ever in a motor vehicle accident?	☐ Yes ☐ No	_____
Any notable falls or injuries?	☐ Yes ☐ No	_____
Any hobby or sports injuries?	☐ Yes ☐ No	_____
Do you smoke? Amount _____	☐ Yes ☐ No	_____
Do you drink alcohol?	☐ Yes ☐ No	_____
☐ Daily ☐ Weekends ☐ Sporadically		
Do you exercise regularly?	☐ Yes ☐ No	_____
☐ Daily ☐ Weekends ☐ Sporadically		
Do you maintain proper posture?	☐ Yes ☐ No	_____
Do you eat as healthy as you think you should?	☐ Yes ☐ No	_____
Are you/have you ever been over your ideal weight?	☐ Yes ☐ No	_____
Do you have occupational stress? (Rate 1-10, 1=none, 10=extreme)	☐ Yes ☐ No	_____
Do you have personal stress? (Rate 1-10, 1=none, 10=extreme)	☐ Yes ☐ No	_____
Do you/have you taken narcotics?	☐ Yes ☐ No	_____
Ever been assessed/fitted for orthotics?	☐ Yes ☐ No	_____
Do you currently take prescription medications?	☐ Yes ☐ No	_____
Sleep posture- ☐ Side ☐ Back ☐ Stomach		_____

FAMILY HEALTH PROFILE

As a family oriented wellness centre, we are not only interested in your health and well-being, but also the health and well-being of your loved ones. Please mention below any health condition or concerns you have about your:

	Names and Ages	Condition(s)
Children	_____	_____
Spouse/Partner	_____	_____
Sister(s)	_____	_____
Brother(s)	_____	_____
Mother	_____	_____
Father	_____	_____
Other	_____	_____

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. This care usually reduces or eliminates symptoms. Then begins Reconstructive/Corrective Care, which corrects the years of damage that occurred when there were few symptoms. Finally, Chiropractic offers a genuine approach to wellness care. Based on these definitions, I have primarily consulted this office because:

☐ I am interested in reaching my optimal health potential (Wellness care).

☐ I have a health concern, and I want the cause of this problem corrected and symptoms relieved (Corrective care).

☐ I am only interested in the relief of pain (Relief care).

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INFORMED CONSENT

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We want your informed consent. This means we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you. If you have any questions, please ask.

Chiropractors locate, analyze, and correct by adjustment, **vertebral subluxations** (spinal dysfunctions) which cause nerve interference. Chiropractic adjustments restore function to the nervous system, networked through your entire body, and allow the **innate** healing power of your body to work at maximum efficiency in order to restore, maintain, and promote your health.

Physicians, Chiropractors, Osteopaths, and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke like occurrences, which are usually of a temporary nature. Tests, with or without x-rays, will be performed on you to minimize this risk. Chiropractic is considered one of the safest and most effective health care treatments.

I understand that to provide me with health goods and services, Inner Wisdom will collect some personal information about me (phone number, address). This information may be shared with any other Chiropractor at this office who may administer treatment to me, or any other therapist or practitioner at Inner Wisdom, as deemed necessary.

I understand that Inner Wisdom has a privacy policy regarding the collection, use and disclosure of personal information, steps taken to protect the information, and my right to review my personal information.

I understand that I might receive the following: newsletters, Thank you cards, phone calls, post cards, health packages, etc., that may be of interest to me.

I have read the above, and consent to examination and treatment by Dr. Jeff Randall. I hereby authorize my doctor (or whomever my doctor designates in his/her absence) to administer appropriate care, as they deem necessary. I clearly understand, and agree that *I am personally responsible for payment of all fees for services rendered by this office, and that accounts are payable when the service is provided.*

Date: _____

Patient's Name: _____

Patient Signature: _____

Witness: _____