

Date: _____

Last Name: _____ First Name: _____

Address: _____ City: _____ Prov: _____ Code: _____

Home Phone: _____ Work Phone: _____ E-mail: _____

How young are you? _____ Sex: Female / Male Family Doctor: _____ Tel: _____

Birth date: _____ Occupation: _____ Employer: _____

Marital Status: Single Married Divorced Separated Widowed Children: Yes No Number: _____

How did you discover our office? _____

If referred, whom may we thank for referring you to our clinic? _____

Care Card #: _____ / _____ / _____ Category: G1 V2 R2 H2 RCMP Social Security # _____

ICBC Claim#: _____ Adjustor: _____ WCB Claim #: _____

Please complete this general health history survey, as it will provide your doctor with important information to better understand your history, your present and long term needs, and any compromise to your wellness or health related quality of life that you many now be experiencing.

Part 1: Your Health Concerns or Symptoms and How They May Affect Your Life

1) Primary reasons for seeking chiropractic care: Please describe the location of complaint.

2) Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging

3) Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

4) Do you have any numbness or tingling in your body? Where? _____

5) Grade Severity of your pain (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain imaginable)

6) When did this situation or concern begin? _____

7) Why do you think this has happened or continues to happen to you? _____

8) How frequent is complaint present, how long does it last? _____

9) Does anything aggravate the complaint? _____

10) Does anything make the complaint better? _____

11) Have you done anything about this situation or concern or gotten any advice or treatment for it? Yes No

If yes, what were you told? _____

12) What was done? _____

13) Did that seem to work? _____

14) Please grade the level to which your complaint(s) affect these aspects of your functioning/quality of life.

0 - No effect	1 - Slight effects	2 - Moderate effects	3 - Drastic effects
Effects on work	0 1 2 3	Effects on recreation/play	0 1 2 3
Effects on social life	0 1 2 3	Effects on walking	0 1 2 3
Effects on exercise	0 1 2 3	Effects on eating	0 1 2 3
			Effects on rest/sleep 0 1 2 3
			Effects on sitting 0 1 2 3
			Effects on love life 0 1 2 3

Comments: _____

Part 2: Health / Trauma / Medical / Chiropractic History

- 1) Have you ever injured your spine (neck, head, back, hips)? Yes No
Please describe: _____
- 2) Have you had a work/motor vehicle accident related injury? Yes No
Please describe: _____
- 3) Please list medications (prescription or non-prescription) you have taken within the past 60 days:

- 4) In the past, have you taken other medications for a period of more than 3 months? Yes No
a) What did you take? _____
b) What was the reason for taking this medication? _____
- 5) Have you had any spinal x-rays, CAT scans or MRI imaging of your spine or head? Yes No
If yes, when: _____
- 6) What were you told about them? _____
- 7) Have you had any surgeries? Please explain: _____
- 8) Have you broken any bones, or significantly sprained part of your body? Yes No
Please explain: _____
- 9) Please list any herbs, nutritional supplements or natural home remedies you take regularly:

- 10) Do you have an exercise program or are you involved in any sports/recreational activity? Yes No
If yes, please describe: _____
- 11) Are there any health problems in your Family Health History: _____
- 12) Any Deaths in immediate family: _____
- 13) Has your spine ever been professionally examined or adjusted by a Chiropractor? Yes No
a) By whom and when? _____
b) Why did you go? _____

Part 3: Stress Survey

Which of the following spinal stressors are you experiencing in your life?

Please rate (Circle):	Mild	Moderate	Extreme
Physical Stress	Mild	Moderate	Extreme
Family stress	Mild	Moderate	Extreme
Personal relationships	Mild	Moderate	Extreme
Work related stress	Mild	Moderate	Extreme
Loss of loved one	Mild	Moderate	Extreme

Signature: _____

Thank you for choosing the Grande Family Chiropractic.

We look forward to helping you regain and maintain your health.