FREDERICTON'S HEALTH SOURCE

WELCOME! We are Honored you chose us to evaluate your health. Please fill out the following information as best you can. If you need assistance please let us know. This information is very important to us and your care and is kept completely confidential. Thank You!

Name: _____ Today's Date: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Date of Birth: _____ Age: _____
Phone: (H) _____ (C) _____ (W) _____
Email: _____
Best way to contact you should we need to: Phone (H/C/W) Email
Job Title: _____ Employer: _____

Who can we thank for referring you to our practice? _____

In case of an emergency, whom should we contact?
Name: _____ Relation: _____
Phone Number: _____
Will you be using Insurance to cover the cost of your treatments at our clinic: Yes No
If you do have insurance and would like us to direct bill your insurance company, if so please give your card to the front desk so we may make a copy and keep it on file.

Reason (s) for consult this office: _____
_____
_____
Is this from a motor vehicle accident: Yes No or a work injury/accident: Yes No

Prior Chiropractic care:
Name: _____ Approx. date of last adjustment: _____
Approx. Number of treatments: _____ Results: Excellent Good Fair Very Poor

Prior Massage Care:
Name: _____ Approx. date of last Massage: _____
Approx. Number of treatments: _____ Results: Excellent Good Fair Very Poor

Prior Physio Therapy
Name: _____ Approx. date of last Massage: _____
Approx. Number of treatments: _____ Results: Excellent Good Fair Very Poor

Medical Doctor:
Name: _____Date of last visit: _____
Was it for the same issue(s) you currently have? Yes No

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Health History

Name: _____ Date: _____

What are your Health/Wellness goals? _____

_____

Rank your health out of 10 (10 being excellent): Currently ___/10 Ideally ___/10

What do you hope to accomplish here? _____

Location:

Current Chief Complaint and its location: _____

_____

_____

_____

Time and Duration:

How often do you experience this pain? _____Constant _____Frequent _____Intermittent

What caused the onset? _____

Date of onset: _____

Severity:

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, please rate the severity of your pain:

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10? _____

What is the least intense the symptom has been on a scale of 0 to 10? _____

What is the most intense the symptom has been on a scale of 0 to 10? _____

Associated Signs/Symptoms:

Please check all that apply · ____Inflexibility _____Stiffness _____Spasms _____Cramps

Does this pain travel or radiate anywhere? (if Yes, where) _____

Quality:

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting

_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Modifying Factors:

What aggravates the pain/symptom?

_____Sneezing _____Lifting _____Exercising _____Looking up/down _____Walking _____Driving

_____Coughing _____Sitting _____ Bending _____Looking side/side _____Standing _____Stress

_____Climbing Stairs _____ Getting out of bed _____Repetitive movement _____Getting in/out of car

Other: _____

What relieves this pain/symptom?

_____Resting _____Sleeping _____Exercising _____Looking up/down _____Shower

_____Advil _____Stooping _____Bending over _____Mineral Ice

_____Other: _____

Over the past weeks/months this complaint is: _____Improving _____Getting worse _____About the same

Have you seen anyone for this condition? _____YES _____NO WHOM?_____

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Chief Complaint

Mark the areas on this body where you feel the described sensation. Use the appropriate symbols and use all that may apply.

Numbness - NNNNNNNNNNNNNN

Burning – BBBBBBBBBBBBBBBBBB

Dull – DDDDDDDDDDDDDDDDDD

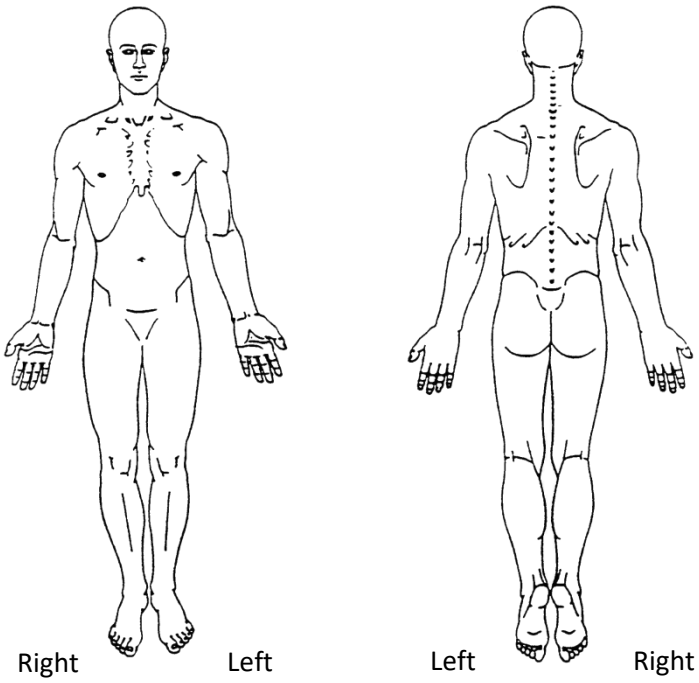
Sharp/ Stabbing – SSSSSSSSSSSSSS

Tingling (Pins and Needles) – TTTTTT

Achy/Stiff - AAAAAAAAAAAAAAAA

Do you have any internal pins, wires or artificial joints? If so, what and where?

_____



Please check the appropriate box(s) for any of the following symptoms you may have (NP=Not Present; P=Present).

Muscle and Joint

NP	P	
☐	☐	Arthritis
☐	☐	Bursitis
☐	☐	Foot problems
☐	☐	Hernia
☐	☐	Low back pain
☐	☐	Neck pain
☐	☐	Shoulder pain
☐	☐	Elbows

Eyes, Ears, Nose, Throat

☐	☐	Chest pain
☐	☐	Chronic Cough
☐	☐	Colds
☐	☐	Difficulty breathing
☐	☐	Asthma/Wheezing
☐	☐	Ear aches/Infections
☐	☐	Sinus Infection
☐	☐	Sore throat

NP	P	
☐	☐	Allergies
☐	☐	Headaches
☐	☐	Loss of Sleep
☐	☐	Nervousness
☐	☐	Depression
☐	☐	Numbness
☐	☐	Bruise easily
☐	☐	Hives/Itching
☐	☐	Hay Fever
☐	☐	Twitching Eyes

Cardio-Vascular

☐	☐	Fast Heart Beat
☐	☐	Slow heart beat
☐	☐	Swelling
☐	☐	High blood pressure
☐	☐	Poor circulation
☐	☐	low blood pressure

Genito-Urinary

NP	P	
☐	☐	Bed wetting
☐	☐	Kidney Infections
☐	☐	Painful Urination
☐	☐	Frequent Urination

Digestive System

☐	☐	Excess hunger
☐	☐	Burping/Gas
☐	☐	Diarrhea
☐	☐	Difficult digestion
☐	☐	Stomach pain
☐	☐	Nausea
☐	☐	Poor Appetite
☐	☐	Constipation

Pain/Numbness

NP	P	
☐	☐	Shoulders
☐	☐	Arms/hands
☐	☐	Hips/Legs
☐	☐	Ankles/feet
☐	☐	Sciatica

NP	P	
☐	☐	Cramps
☐	☐	Heavy Flow
☐	☐	Irregular cycle
☐	☐	Miscarriages

Are You pregnant? ___

Due Date: _____

Do you have a pacemaker?____

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PLEASE LIST PAST SURGERIES:

1. _____ Year_____ 2. _____ Year_____

3. _____ Year_____ 4. _____ Year_____

List any key slips, falls or MV accidents you've had from childhood to present (Including Date)

1)_____

2) _____

3)_____

What medications, birth control are you currently taking? (Include Date)

1)_____ 2) _____

3) _____ 4) _____

5) _____ 6)_____

Do you have any Allergies?_____

What Vitamins are you currently taking?_____

_____

LIFESTYLE

Number of Children: _____ Children's Name(s): _____

Frequency of Exercise: ____Never ____Rarely ____Occasionally ____Moderately ____Regularly

Intensity of Exercise: ____Low Level ____Medium Level ____High Level ____Competition Level

Types of exercise you enjoy: _____

Sufficient Rest: ____Never ____Rarely ____Occasionally ____Moderately

Hours of Sleep: _____4 ____6 ____8 ____10 ____More than 10

Well balanced diet: ____Never ____Rarely ____Occasionally ____Moderately

How many glasses of water per day do you drink? _____

Do you smoke (per day)? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____1+packs/day

Do you drink caffeinated beverages?(per day) ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5

Do you drink alcoholic beverages? ____No ____Occasionally ____1 to 2 ____2 to 3 ____4 to 5 ____More

Hobbies: _____

Current Stress

Rank your current level of Personal stress? _____Very low _____Moderate _____Very High

Rank your current level of Physical Stress? _____ Very Low _____ Moderate _____Very High

Rank your current level of Chemical stress (Processed food, Medications, etc) ____Low ____Moderate _____High

Rank your current level of Career Stress? _____ Very Low _____ Moderate _____Very High

Rank your current level of Emotional stress? _____ Very Low _____ Moderate _____Very High

Anything that you would like to add to help us give you the best possible care?_____

_____

FOR MASSAGE: (please initial the following indicating you understand the health forms you filled out and grant permission to have your health care evaluated and to receive massage therapy)

1. (For Massage appointments) I am aware that draping will be used during the massage_____
2. I understand my feedback is an essential element in my treatment and therefore if at any time I should become uncomfortable during the session, I may bring it to my therapist attention _____
3. If I am unable to keep an appointment , I understand 24 hours' notice is required to change the time otherwise I will be charged for the session that I have reserved _____
4. Payment is required in full at each visit _____

I have read and full understand this for in its entirety. If at any time there are changes in the information given or in my condition, I will notify my therapist. The treatment(s) given here is for the sole purpose of stress reduction, relief from muscle tension of spasm and to increase circulation and energy flow.

The therapist does not diagnose or prescribe for mental illness, disease or any other physical or mental disorder. The massage therapist does not perform spinal manipulations. Massage Therapy is not a substitute for medical examination or diagnosis and it is recommended that a physician be seen.

It is the Client's (your) responsibility to explain and discuss all physical conditions with the therapist so that they may do their job.

Client Signature: _____ Therapist signature:_____
Date: _____

FOR CHIROPRACTIC PATIENTS: (please initial the following indicating you understand the health forms you filled out and grant permission to have your health care evaluated)

1. If I am unable to keep an appointment , I understand 24 hours' notice is required to change the time otherwise I will be charged for the appointment that I have reserved _____
2. Payment is due in full at the time of service. If you wish to have your insurance direct billed please give your insurance card to the front desk._____

Our goal at Fredericton's Health Source is to provide you with exceptional, detailed assessment of your health. We want to provide you the resources for superior care and get your body back to its absolute peak potential.

I consent to a Chiropractic, Neurologic and Orthopedic evaluation and grant permission to receive the evaluation that includes this history. If the Doctor prescribes X-ray that shall be communicated and consent for the Xray is given. Any findings will be communicated to me before treatment and will remain confidential between myself and my Doctor.

Consenting Signature: _____ Doctor Signature: _____
Date: _____