

Date: _____

Update – Re-assessment

Personal information

Name: _____ Email: _____

Address: _____ City _____ Prov _____ Postal code _____

Home Phone: _____ Work: _____

Cell Phone _____

Birth Date (dd/mm/yyyy) _____ / _____ / _____ Age _____ Male Female

Occupation & Employer _____

Marital Status S M C/L D W

→Emergency Contact: _____ Phone number _____

Are you a student? Yes No If yes, where? _____

Status of chiropractic care

Main reason for chiropractic care: Wellness Pain control Back pain Neck pain Headaches

Other: _____

When was your last chiropractic treatment? _____

How do you feel today? (No pain) 0---1---2---3---4---5---6---7---8---9---10 (Debilitating)

Mark the areas of your body where you feel the described sensations. Use the appropriate symbol, include ALL affected areas.

Ache: AAAA

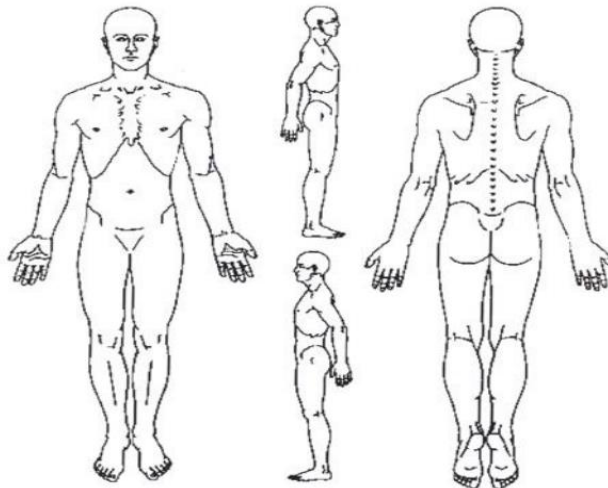
Numbness: NNNNN

Pins and Needles: PPPP

Burning: BBB

Stabbing: SSS

Throbbing: TTT



Name: _____

Date: _____

HEALTH HISTORY

Please mark **C** beside the condition(s) you currently have

Please mark **P** beside the conditions you have had in the past

Musculoskeletal System

- ___ neck problems
- ___ jaw problems
- ___ upper back problems
- ___ shoulder problems
- ___ elbow / wrist problems
- ___ low back problems
- ___ ankle / foot problems
- ___ arthritis
- ___ osteoporosis
- ___ muscle soreness
- ___ scoliosis

Nervous System

- ___ headaches
- ___ loss of feeling
- ___ numbness
- ___ dizziness
- ___ fainting
- ___ loss of balance
- ___ confusion
- ___ depression
- ___ forgetfulness
- ___ fatigue
- ___ anxiety

Systemic

- ___ Diabetes
- ___ Hypoglycemia
- ___ Epilepsy
- ___ Rheumatoid
- ___ TB
- ___ HIV / AIDS
- ___ Cancer: _____
- ___ MS
- ___ Parkinson's
- ___ Thyroid problems
- ___ other: _____

Ear, Eyes, Nose, Throat

- ___ eye problems
- ___ vision problems
- ___ ear discharge
- ___ ear pain
- ___ ear ringing
- ___ hearing loss
- ___ sore throat
- ___ hoarseness
- ___ enlarged glands

Circulatory system

- ___ high blood pressure
- ___ high cholesterol
- ___ heart condition
- ___ aneurysm
- ___ stroke
- ___ varicose veins
- ___ diarrhea

Gastrointestinal system

- ___ poor appetite
- ___ excessive hunger
- ___ abdominal pain
- ___ stroke
- ___ nausea / vomiting
- ___ diarrhea
- ___ constipation
- ___ black / bloody stool
- ___ liver trouble
- ___ gallbladder trouble
- ___ weight trouble
- ___ ulcer

Genito-Urinary system

- ___ painful urination
- ___ excessive urination
- ___ scanty urine
- ___ discoloured urine
- ___ excessive thirst

Female

- ___ vaginal discharge
- ___ vaginal bleeding
- ___ pregnancy
- ___ menstrual pain
- ___ irregular cycle
- Menopausal? Yes No
- Pregnant? Yes No
- Due date: _____

Pulmonary

- ___ Asthma
- ___ chest pain
- ___ difficulty breathing
- ___ persistent cough

Allergies

- ___ seasonal
- ___ hay fever
- ___ sinus pain
- ___ drug allergy
- ___ food allergy
- ___ other: _____

Men

- ___ prostate problems

Other: _____

Any broken bones? Yes No

Any loss of consciousness? Yes No

Any accidents or injuries? Yes No

Surgeries? Yes No

Name: _____

Date: _____

FAMILY HEALTH HISTORY

Please check any boxes that apply to anyone in your Family (not including you)

- High blood pressure Rheumatoid Arthritis Breathing or lung problems Heart disease Osteoarthritis
 Cancer: _____ Stroke High cholesterol Neurological problems
 Diabetes (Type I or Type II) Thyroid / Hormone problems Other: _____

HEALTH & LIFESTYLE

Your condition(s) may be affected by your environment, the foods you eat, and your lifestyle activities and habits. Please answer the following:

Please list any medications you are currently taking and for how long: _____

Please list any nutritional supplements you are currently taking and for how long: _____

Do you exercise regularly? No Moderate Daily Activities: _____

How would you describe your eating habits? Excellent Good Fair Poor

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

Do you Smoke? Yes No If yes, how long and how much? _____

Do you drink alcohol? Yes No If yes, how much? _____

Do you sleep well at night? Yes No If no, why? _____

Is your job stressful? Yes No If yes, why? _____

Have you had any recent changes in body weight? Yes No If yes, how much? _____

List any major life stresses over the last year: _____

List any enjoyable hobbies you participate in: _____

HEALTH GOALS

Are you satisfied with your current overall health? Yes No

What things would you like to change/improve about your current level of health? Please explain: _____

What is preventing you from achieving your goals?

Is there anything else that you are concerned about or would like advice about? _____

The information on this form is true to the best of my memory and I consent to further evaluation as deemed appropriate by the Chiropractor:

Signature of patient or legal guardian

Date