Please list **KNOWN ALLERGIES** (food or drug) or “**MEDIC-ALERT**” CONDITIONS

Personal Information

Today's Date | Date of Birth
First Name | Last Name
Address
City | Province | Postal
Home Phone | Work Phone
Can we leave messages Y / N
Email

Emergency Contact
Medical Doctor | Other Practitioners
How did you hear about us?

This record of your medical history is confidential. Information it contains will not be released to any person unless you authorize me to do so.

Current Medications and Natural Health Products

Product	Dosage	Taken Since

General State of Health

1. Is your health currently getting better, worse, or staying the same?

2. What are the most significant measures which you have taken to date, to improve your state of health?

— —
— —
— —
— —
— —
— —
— —

Current and Past Medical Conditions

—	—
—	—
—	—
—	—
—	—
—	—

Reasons for your visit today

Prioritize your health-related concerns, below.

—	—
—	—
—	—
—	—
—	—
—	—
—	—
—	—

Lifestyle

What do you feel your weakest organ system is, and why? (heart, kidneys, lungs, etc.)

What is the quality of your sleep? (good/poor)	How many hours do you sleep?
Difficulty falling or staying asleep? (Y/N)	Do you wake frequently? (Y/N)
Do you wake refreshed? (Y/N)	

Have you had any significant dental work? (Y/N) Any adverse reactions?

Have you had any recent vaccinations? (Y/N) Any adverse reactions?

Do you smoke? (Y/N)	Have you quit in the last 5 years? (Y/N)
Do you drink alcoholic beverages? (Y/N)	How many per week?
Do you drink caffeinated beverages? (Y/N)	How many per day?

Do you do any sort of stress-relieving activities? How do you cope with stress?

Review of Body Systems

General
❏Headaches
❏Poor / change in appetite
❏Weight change ↑↓ ____lbs
❏Poor sleep
❏Fatigue
❏Chills and fevers
❏Night sweats
❏Excessive sweating
❏Cravings ❏ Intense hunger
❏Intense thirst

Skin and Hair
❏Rashes ❏ Itching ❏ Hives
❏ Eczema
❏Acne, boils
❏Loss of hair ❏ Dandruff
❏Nail changes
❏Recent mole colour change

Eyes Ears Nose Throat
❏impaired hearing
❏ear aches ❏ infections
❏ringing in ears
❏ear wax build up
❏sinus infections
❏enlarged thyroid
❏recurrent sore throats / tonsillitis
❏nasal obstruction
❏post nasal drip
❏nosebleeds
❏eye strain ❏ blurry vision
❏night ❏ colour blindness
❏Change in Prescription Lenses
❏cataracts
❏itchy/red eyes
❏facial pain/tics
❏jaw pain or clicks
❏mercury fillings
❏sores in mouth
❏loss of taste

Cardiovascular
❏ ↑ ↓ blood pressure
❏Irregular heartbeat
❏Dizziness / Fainting
❏Chest pain
❏Angina
❏Anemia
❏Easy bruising/bleeding
❏Varicose veins
❏Cold hands or feet
❏Swelling of limbs
Date of last CBC: ___/___/______

Muscle, Bone & Joints
❏Back pain
❏Muscle spasms/cramps
❏Muscle weakness
❏Arthritis ❏ Bursitis
❏Joint pain/stiffness

Respiratory
❏Difficulty breathing
❏Chronic cough
❏Sputum
❏Pneumonia/Bronchitis
❏Asthma
❏Coughing blood
❏Shortness of breath
❏Wheezing
❏Unresolved grief
❏Nightmares/dreams
❏Dark circles under eyes

Gastrointestinal
STOMACH
❏Ulcers
❏Hiatal Hernia
❏Indigestion / Heartburn
❏Gas or burping
❏Bad breath
❏Constipation
❏Antacid use
PANCREAS
❏Undigested food in stool
❏Diarrhea
❏Nausea
❏Pass gas frequently
❏Chronic worry
LEAKY GUT
❏Abdominal pain/ cramps
❏Autoimmune disease
❏(family or self)
❏Drink alcohol
❏High dairy intake
❏Constipation/Diarrhea
COLON FLORA
❏Coated or fuzzy tongue
❏Incomplete bowel movements
❏IBS or colitis
❏Bad breath
❏Burning ❏ Itching Anus
❏Skin erruptions/bumps
❏Yeast Infections
❏Anti-biotic use
❏HRT or Birth Control Pill
❏Intestinal pain for no reason
❏Frequent illness
❏Tired all the time
LIVER
❏Hepatitis ❏ Jaundice
❏Difficulty with fatty foods
❏Burning Feet
❏Drink Alcohol
❏Sensitive to fumes/chemicals/smells
❏Brown spots on skin
❏Chronic anger/frustration

Neurological
❏Depression
❏Irritable
❏Poor memory
❏Dizziness
❏Lack of co-ordination
❏Seizures
❏Concussion
❏Numbness of feet
❏Emotional fluctuation

Genito-Urinary
❏Frequent ❏ urgent urination
❏Pain on urination
❏Recurrent urinary tract infections
❏Wake at night to urinate
❏Incontinence
❏Kidney stones ❏ infections
❏Sores on genitals
❏Blood in urine
❏ Day to day fear

Adrenal Fatigue
❏ Difficulty maintaining chiropractic adjustments
❏ Crave salt
❏ Low Blood Pressure
❏ Slow recovery from colds
❏ Muscular or nervous exhaustion
❏ Abrupt stop of menstruation
❏ Chronic fatigue
❏ Slow start in morning

Adrenal Stress
❏ Anxiety
❏ Trouble sleeping
❏ Craving coffee or sweets in am
❏ Shaky/dizzy when delayed meals
❏ Retaining water
❏ Under a lot of stress?
❏ Tired/sleepy in afternoon
❏ Eat refined sugar/sweets

Female
❏Irregular ❏ Painful periods
❏Heavy ❏ Light Flow
❏Blood clots
❏Using birth control _______
❏Pain during intercourse
❏Vaginal discharge ❏ itching
❏Yeast infections
❏STD's ❏ Vaginal sores
❏Sore breasts
❏Do self breast exams?

Date of last Pap ______________
Age of first menses ____________

Menopausal Y N
Age of last menses ____________

Pregnant? Y N
Number of: pregnancies _____
abortions ________
miscarriages _____
births ___________

Male
❏ Testicular masses
❏ Do testicular self-exams
❏ Testicular pain
❏ Impotence
❏ STD's
❏ Discharge sores
❏ Prostate problems

Family Medical History

❏ Check here if you were adopted (biological family history unknown)

Family Member	Age if Alive	Age at Death	Ailments
Mother			
Her Mother			
Her Father			
Father			
His Mother			
His Father			
Children			
Siblings			

Are there any other specific health or health-related concerns not mentioned in this questionnaire that you would like to discuss?