HEALTH HISTORY FORM – CHIROPRACTIC/TRIGENICS

MOTION HEALTH CENTRE

PATIENT INFORMATION

Date: _____/_____/_____

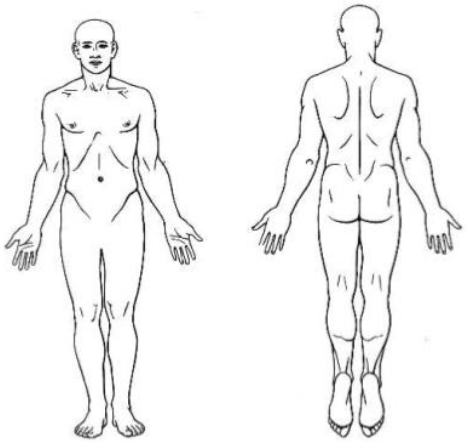
First Name: _____ **Last Name:** _____ **DOB:** ____/____/_____ **Male** ◯ **Female** ◯

HOW CAN WE HELP YOU?

Please list the reasons that bring you in today. *(If you have no symptoms or complaints and are here for a health check or Chiropractic/Trigenics Wellness please still list, i.e., posture or muscle balance check, sports optimisation, wellness care, etc.)*

Please list your health concerns according to their severity. Include location.	Rate symptom severity 0 = none/mild to 10 = worst imaginable	When did this episode start?	Have you had this symptom/condition before? When?	Did the problem begin with an injury? (Y/N)	% of the time symptom is present
1.					
2.					
3.					

Please circle areas to the right where you have pain or other symptoms:



What does your symptoms/complaint feel like? (Check where appropriate)

◯ Numbness ◯ Sharp ◯ Tight / Restricted
◯ Tingling ◯ Shooting ◯ Weak / Under Performing
◯ Stiffness ◯ Burning ◯ Imbalanced
◯ Dull ◯ Throbbing ◯ Pounding
◯ Aching ◯ Stabbing ◯ Radiating / Referring
◯ Cramping ◯ Swelling ◯ Catching / Jamming
◯ Nagging ◯ Other _____

IMPACT OF YOUR SYMPTOMS

How are these symptoms / conditions interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self Care	☐	☐	☐	☐	Other_____	☐	☐	☐	☐

How committed are you to correcting these issues? Circle number.

0 1 2 3 4 5 6 7 8 9 10

0 = NOT COMMITED 10 = VERY COMMITED

GENERAL HEALTH HISTORY & LIFESTYLE

Have you had any surgeries, the type, when and why? _____

_____

Have you had any accidents/injuries (i.e., fractures, sprains, auto, work related, other?) _____

_____

Do you smoke?	◯ Yes ◯ No	Do you eat healthy foods?	◯ Yes ◯ No ◯ Unsure
Do you drink alcohol?	◯ Yes ◯ No	Do you exercise regularly?	◯ Yes ◯ No ◯ Unsure
Do you drink adequate water?	◯ Yes ◯ No ◯ Unsure	Are you physically stressed?	◯ Yes ◯ No ◯ Unsure
Are your teeth healthy?	◯ Yes ◯ No ◯ Unsure	Are you mentally stressed?	◯ Yes ◯ No ◯ Unsure
Have you been hospitalized?	◯ Yes ◯ No ◯ Unsure	Do you wear orthotics in shoes?	◯ Yes ◯ No ◯ Unsure

PATIENT WELLNESS ASSESSMENT

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality sleep Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% Function Continuous development Active participation Wellness Lifestyle

On the diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE: _____

SHORT TERM: _____

LONG TERM: _____

People consult this office with one or more of the following objectives. Please indicate any which apply to you.

◯ Relief of my symptoms ◯ Correction of my underlying problems ◯ To maximize my health

◯ To maximize myself, my family's and community health.

HEALTH & ILLNESS HISTORY

(Please check the boxes beside any condition that you have or have had)

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anxiety
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma/Allergies
- ☐ Back Pain
- ☐ Cardiovascular Issues
- ☐ Cancer
- ☐ Circulation Issues
- ☐ Childhood Illness
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes
- ☐ Digestive Issues (Constipation/Diarrhea/GERD/IBS)
- ☐ Elbow/Wrist/Hand Issues
- ☐ Endocrine Issues (Thyroid)
- ☐ Epilepsy
- ☐ Foot/Ankle Issues
- ☐ Gout
- ☐ Headaches / Migraines
- ☐ Heart / Coronary Disease
- ☐ Hepatitis
- ☐ Hip Issues
- ☐ Immune Issues
- ☐ Irregular Periods
- ☐ Knee Issues
- ☐ Lung / Breathing Issues
- ☐ Lymphatic Issues
- ☐ Menstrual Cramps
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Neck Pain
- ☐ Night Sweats
- ☐ Osteoporosis
- ☐ Pain at Night
- ☐ Reflux
- ☐ Reproductive Issues
- ☐ Ringing in Ears
- ☐ Scoliosis
- ☐ Shoulder Issues
- ☐ Sinus Issues
- ☐ Stroke
- ☐ TMJ / Jaw Issues
- ☐ Ulcers
- ☐ Urinary Issues
- ☐ Venereal Disease
- ☐ Other _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)

CHILDREN

How many children do you have?_____

Children's ages? _____

Children's health concerns? _____

PREGNANCY

Are you currently pregnant? ◯ No ◯ Yes, I am due _____

Number of past pregnancies? _____

Health concerns regarding this pregnancy? _____