



Health History Questionnaire

Name: _____ Date: _____

Please complete this health history questionnaire, as it will provide us with important information to better understand your health as well as your desired outcomes for care in our office. The information you give is confidential and will only be used for the Doctor's clinical records.

What is your present reason for consulting our office?

- Maximizing personal health potentials
- Improving family and/or community health
- Preventing disease, symptoms and infirmities
- Disease, symptoms and infirmities

Part 1 : Health Concerns and Symptom Patterns

1) What are the current concerns you have about your health? Include concerns that stem from past, present and future events.

2) When did these concerns begin?

3) Have you sought advice or undertaken self-care for these concerns? Yes No
If yes, what was done, or what were you told

4) Did that seem to work?

5) What was different about *you* after treatment?

6) What was different about *your condition or symptom* after treatment?

7) What was different about *your concern about the condition or symptom* after treatment?

8) Since your health concern(s) began : (Please circle)

A) Have you changed your habits? Yes No

B) Held or touched part of your body more or differently? Yes No

C) Moaned, cried or made sounds that you usually do not make? Yes No

9) Which best describes your current feelings about yourself and your situation? (Please choose **one**)

A) I feel helpless, like little or nothing works

B) This is terrible, really bad, I am scared, and hope you can fix it for me

C) I feel stuck, and can't help myself right now

D) I deserve more than what I have been experiencing, and would like you to assist me in my healing

E) I feel like I've made some progress with my concern, but would like further progress with assistance

F) Anything else...

10) Has any other family member had the same or similar concerns? Yes No

If Yes, What did he/she do about them?

Part 1: Continued

11) Did it seem to work? _____

12) Using the scale below, how aware of this are you during the day? 0 1 2 3 At night? 0 1 2 3
(0—not aware at all, 1-slightly aware, 2-moderately aware, 3-extremely aware)

13) Is there any time, or activity you can be involved with when you totally or almost completely forget about this condition, symptom or concern? _____

14) Is there any time of day or activity which makes you aware of it? _____

15) What do you think is the cause of your health concern? _____

16) Do you think this is the sole cause? Yes No
If No, what else is involved? _____

17) If this condition, symptom or concern were to go away tomorrow, what would be different about your life? _____

18) What are you doing in your life now that is different than what you would be doing if you did not have this condition, symptom or concern? _____

19) Please grade the following on a scale of 0 to 3. **(0—not at all, 1-slight, 2-moderate, 3-extreme)**
Currently, how inconvenient is your condition, symptom or concern **0 1 2 3**
How inconvenient was it in the past **0 1 2 3**

Part 2: General and Lifestyle Health

1) How would you describe your lifestyle or health with regards to each of the following categories :
(Please circle one)

Exercise	Poor Fair Good Excellent	Stress	No stress Low level Moderate Stressed out
Diet	Poor Fair Good Excellent	Rest	Poor Fair Good Excellent

2) Have you had or do you continue to receive any of the following vehicles towards growth, healing and development: (Please circle all that apply)

chiropractic massage bodywork kinesiology yoga pilates chelation homeopathy naturopathy
acupuncture ayurvedic medicine Qi Gong Tai Chi meditation music therapy dance therapy
herbalist psychotherapy rebirthing breath work movement therapy cranio-sacral therapy
Traditional Chinese medicine nutritional therapy O2 therapy somato-respiratory integration reiki
Others? _____

3) Do you have an exercise, meditation, prayer, nutritional or dietary program? Yes No
If Yes, please describe _____

4) When stressed, how do you “centre” yourself or “re-group”? _____

5) Is there some aspect of your life that very much pleases you, brings you joy or helps you to feel better about yourself? _____

The practices of **Chiropractic** and **Network Spinal Analysis** are based on the location and transformation of nervous system interference and tension. These interferences are caused by any stress your body can not optimally perceive, adapt to or recover from. These stresses can be physical, chemical or emotional in nature. The next section will help your Doctor get an overview of these tensions and stresses and their rhythms in your life.

Part 3: Physical Stress

Birth Stress : Was your mother ill during pregnancy? Yes No

If Yes, please describe _____

Please circle details of your birth, if known :

birth canal c-section drug induced prolonged breech forceps/suction

The spine and nervous system are the most neglected part of a child's health. 80% of children have unresolved nerve interference due to trauma involved with the birth process.

Please circle stressors in the time frame they were/will be part of your life and provide specific information on each where possible:

(C=child, T=teenager, A=adult (in the past), N=now, NF= near future)

List Instances

Slips/Falls	C	T	A	N	NF	_____
Sports Injuries	C	T	A	N	NF	_____
Poor Posture	C	T	A	N	NF	_____
Extensive Computer Work	C	T	A	N	NF	_____
Carrying Heavy Purse/Child/Bag	C	T	A	N	NF	_____
Repetitive Lifting/Bending	C	T	A	N	NF	_____
Continuous Sitting/Standing	C	T	A	N	NF	_____
Bone Fracture/Surgery	C	T	A	N	NF	_____
Driving for many hours	C	T	A	N	NF	_____
Car Accidents	C	T	A	N	NF	_____
Work Injuries	C	T	A	N	NF	_____

In which position do you spend most of the night sleeping ? stomach side back

Part 4: Chemical Stress

Please list any medications, nutritional supplements, herbs or other natural home remedies you take regularly:

Using the same process as above, circle the stressors in your life:

Specifics

Smoker	C	T	A	N	NF	_____
Second-Hand Smoke	C	T	A	N	NF	_____
Poor Diet	C	T	A	N	NF	_____
Caffeine - How much?	C	T	A	N	NF	_____
Refined Sugars	C	T	A	N	NF	_____
Artificial Sweeteners	C	T	A	N	NF	_____
Prescription Drugs	C	T	A	N	NF	_____
Over-The-Counter Drugs	C	T	A	N	NF	_____
Environmental (Pollution)	C	T	A	N	NF	_____



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Welcome Form

Last Name: _____

First Name : _____

Address : _____

City: _____ Postal Code : _____

Best Phone number to reach you at: _____ Cell/Home/Work

2nd Best number to reach you at : _____ Cell/Home/Work

E-mail Address : _____

Date of Birth (dd/mm/yy) : _____ / _____ / _____ Age: _____

Occupation : _____ Marital Status: _____

Name of Spouse: _____ Age: _____

Children : Yes No If yes, how Many? _____

Names & Ages? _____

Who may we thank for referring you to our office? _____

Have you ever had your nervous system examined professionally? Yes No

If Yes, when and by whom? _____

Have you received chiropractic spinal adjustments by a Doctor of Chiropractic? Yes No

If Yes, when and by whom? _____