Adult Consultation History

Your Name: _____Phone:_____

Address: _____

City: _____ Postal Code: _____ Birth Date: _____

(Day/Month/Year)

Email Address: _____

Your Occupation: _____ Employer: _____

Employer Address: _____Phone: _____

(If can be reached there)

Spouse's Name: _____

Medical Doctor: _____

How did you hear about our clinic? _____

Your Main Complaint: _____

Any other Complaints: _____

How long have your suffered with this problem? _____

What have you tried to do to get rid of this problem that DID NOT work? _____

_____

How does this problem interfere with the following areas of your life?

WORK: _____

FAMILY: _____

HOBBIES: _____

LIFE: _____

What do you do that makes this problem worse? _____

What gives you some temporary relief? _____

What is the pattern of this problem? Constant ◉ Intermittent ○ Occasional ○ Cyclic ○

How did it start? _____

Is this a Worker's Safety & Insurance Board (WSIB) case? YES/NO If yes, Date of accident: _____

Have you been involved in a motor vehicle accident? YES/NO If yes, Date of accident: _____

Any difficulties from this? _____

Is there any other information you would like us to know? _____

_____

_____

_____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

I know that the office has a Privacy Code, and I can ask to see the code at any time. I agree that Fairway Chiropractic Centre can collect, use and disclose personal information about me as set out in the office's privacy policies.

Signature: _____ Date: _____

Thank you!

Fairway Chiropractic Centre

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Kitchener, ON N2C 2J6

Tel: 519-748-5535 Fax: 519-748-5599

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HEALTH QUESTIONNAIRE

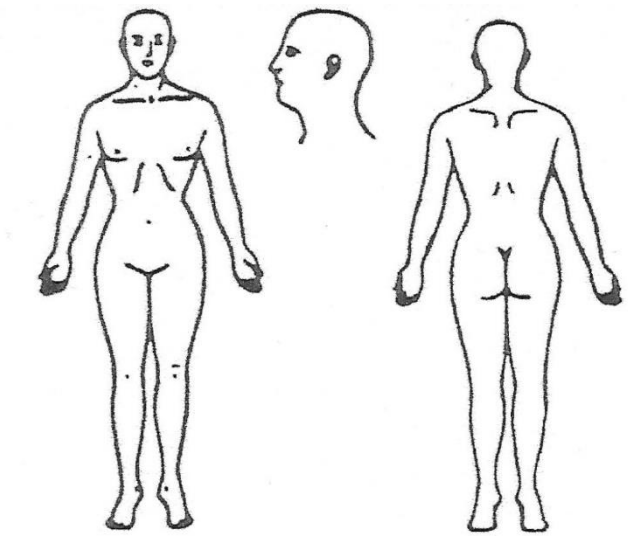
PATIENT NAME: _____ DATE: _____

Please indicate if you have experienced any of the following by using

1 for **Presently have** and **2** for **Previously had**

	MUSCULO-SKELETAL SYSTEM		GASTRO-INTESTINAL SYSTEM		CARDIO-VASCULAR-RESPIRATORY
	Low back problems		Poor appetite		Chest pain
	Pain between shoulders		Excessive hunger		Difficult breathing
	Neck problems		Difficult chewing		Persistent cough
	Arm problems		Difficult swallowing		Coughing phlegm
	Leg problems		Excessive thirst		Coughing blood
	Swollen joints		Nausea		Rapid heartbeat
	Painful joints		Vomiting food		Blood pressure problems
	Stiff joints		Vomiting blood		Heart problems
	Sore muscles		Abdominal pain		Lung problems
	Weak muscles		Diarrhea		Varicose veins
	Walking problems		Constipation		
	Ruptures		Black Stool		**EYE, EAR, NOSE AND THROAT**
	Broken Bones		Bloody stool		Eye strain
			Hemorrhoids		Eye inflammation
	GENITO-URINARY SYSTEM		Liver Trouble		Vision Problems
	Bladder trouble		Gall bladder problems		Ear pain
	Excessive urine		Weight trouble		Ear noises
	Scanty urination				Hearing loss
	Painful urination		**NERVOUS SYSTEM**		Ear Discharge
	Discolored urine		Numbness		Nose pain
			Paralysis		Nose bleeding
	FEMALE		Dizziness		Nose discharge
	Vaginal discharge		Fainting		Difficult breathing thru nose
	Vaginal bleed		Headaches		Sore gums
	Vaginal pain		Muscle jerking		Dental problems
	Breast pain		Convulsions		Sore mouth
	Lumps on Breast		Forgetfulness		Hoarseness
			Confusion		Difficult speech
			Depression		

<u>Please mark</u> your areas of pain on the figures shown below.



Childhood Diseases: _____

_____

Complications: _____

_____

Prior Surgery: _____

_____

Medication presently taking:_____

_____

Previous Accidents:_____

_____

Mother Living? YES / NO **In good health?** YES / NO

Father Living? YES / NO **In good health?** YES / NO

FAMILY HEALTH HISTORY

PATIENT NAME: _____ DATE: _____

Please review the diseases and conditions listed below and indicate those that are health problems of a family member and who the family member is whether it is your Mother, Father, Siblings, Spouse or Children.

CONDITION	YES/NO	RELATION	CONDTION	YES/NO	RELATION
ADHA			EMOTION ISSUES		
ALLERGIES			EMPHYSEMA		
ARTHRITIS			EPILEPSY		
ASTHMA			HEADACHES		
AUTISM			MIGRAINES		
BACK TROUBLE			HEARTBURN		
BED WETTING			HEART TROUBLE		
BURSITIS			HIGH BLOOD PRES.		
CANCER			IBS		
CHEST PAIN			INDIGESTION		
COLIC			INFERTILITY		
COLITIS			INSOMNIA		
CONSTIPATION			KIDNEY TROUBLE		
CROHN DISEASE			NECK PAIN		
DEPRESSION			NERVOUSNESS		
DIABETES			NEURITIS		
DIARRHEA			PINCHED NERVE		
DISC PROBLEMS			SCOLIOSIS		
DOWN SYNDROME			SINUS TROUBLE		
EAR INFECTIONS			OTHER		

ADDITIONAL COMMENTS:

_____

_____

_____

_____