SOUL BEAUTY
HEALING CENTER

Chiropractic
Health History and Entrance Form

A complete health history helps us ensure it is safe to provide you with a chiropractic treatment; please let us know if your status changes so we can update your form. All information given to us is confidential.

Name _____ Email _____
We collect your email address to send you appointment reminders. Your email address will never be shared with a third party.

Home Phone _____ Cell Phone _____ Work Phone _____

Street _____ Unit _____ City _____ Prov. _____ Postal Code _____

Date of Birth (MM-DD-YY) _____ Age _____ Gender _____ Occupation _____

Emergency Contact name and number _____

Personal Health Care # (AB only) _____ How did you hear about us? _____

Do you have insurance coverage for Chiropractic Care? ☐ Yes ☐ No If yes, were you referred by your doctor? ☐ Yes ☐ No

Doctor's Name _____ Phone _____ Last Check-Up Date _____

Doctor's Street _____ Unit _____ City _____ Prov. _____ Postal Code _____

Have you had a chiropractic treatment before? ☐ Yes ☐ No If yes, approximate date of last chiropractic treatment _____

Do you see other healthcare practitioners? ☐ Massage ☐ Physio ☐ Naturopath ☐ Osteopath ☐ Other _____

Is this a workplace injury? _____

Previous Major Illnesses/Operations (include dates) _____

Allergies/Hypersensitivities _____

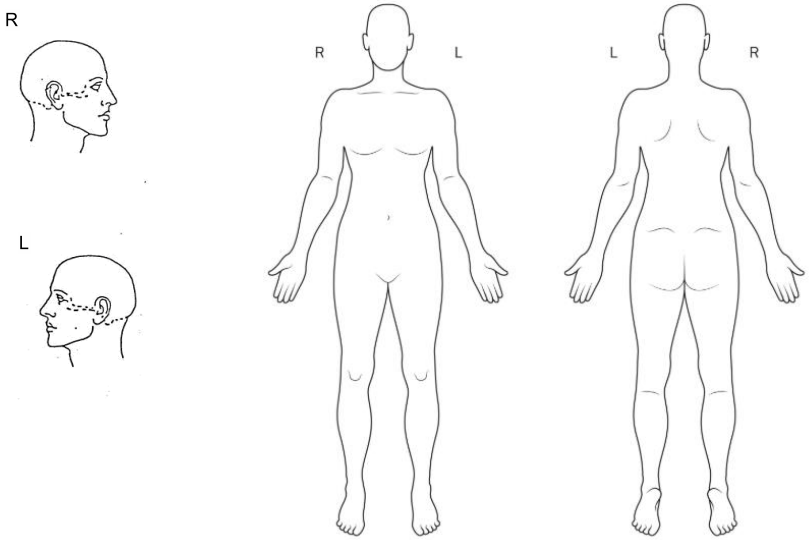
Current Medications _____

Major Accidents (include dates) _____

Other Serious Medical Conditions _____

Family History of _____

In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below. Please draw in the face on the diagram.



SYMBOLS:

Numbness	=======
Burning	x x x x x x
Dull & aching	? ? ? ? ? ?
Pins and Needles	ooooo
Stabbing & Sharp	~~~~~
Stiff & Tight	2 2 2 2 2

For any **current** conditions or symptoms that are causing problems, please ✓ the box in the **C** column.
For any **past** conditions or symptoms, please ✓ the box in the **P** column.

Gastrointestinal

C P
☐ ☐ Poor appetite
☐ ☐ Indigestion
☐ ☐ Excess hunger
☐ ☐ Belching or gas
☐ ☐ Vomiting
☐ ☐ Pain over stomach
☐ ☐ Constipation
☐ ☐ Hemorrhoids (piles)
☐ ☐ Jaundice
☐ ☐ Gall bladder trouble
☐ ☐ Intestinal worms
☐ ☐ Ulcer
☐ ☐ Diabetes
☐ ☐ Diarrhea

Neurologic

C P
☐ ☐ Dizziness
☐ ☐ Fainting
☐ ☐ Problem speaking
☐ ☐ Problem swallowing
☐ ☐ Blurred vision
☐ ☐ Double vision
☐ ☐ Clumsiness
☐ ☐ Numbness or tingling

Cardiovascular

C P
☐ ☐ Bleeding disorder
☐ ☐ High blood pressure
☐ ☐ Chest pain
☐ ☐ Stroke
☐ ☐ Hardening of arteries
☐ ☐ Varicose veins
☐ ☐ Swelling of ankles
☐ ☐ Poor circulation
☐ ☐ Heart/blood disease
☐ ☐ Angina

Respiratory

C P
☐ ☐ Asthma
☐ ☐ Chronic cough
☐ ☐ Spitting up phlegm
☐ ☐ Spitting up blood
☐ ☐ Difficulty breathing

General Symptoms

C P
☐ ☐ Loss of Consciousness
☐ ☐ Blackouts
☐ ☐ Headache
☐ ☐ Fever
☐ ☐ Excess Sweating
☐ ☐ Night sweats
☐ ☐ Loss of Weight
☐ ☐ Night pain
☐ ☐ Generalized pain
☐ ☐ Convulsions

Genitourinary

C P
☐ ☐ Trouble urinating
☐ ☐ Blood in urine
☐ ☐ Kidney infection
☐ ☐ Bedwetting
☐ ☐ Prostate trouble

Menstrual related

C P
☐ ☐ Painful menstruation
☐ ☐ Excessive flow
☐ ☐ Hot flashes
☐ ☐ Irregular/absent cycle
☐ ☐ Cramping/backache
☐ ☐ Abnormal vaginal discharge
☐ ☐ Swollen breasts
☐ ☐ Lump in breasts

Have you had a bone density scan?
☐ Yes ☐ No
Currently on birth control?
☐ Yes ☐ No

Previously on birth control?
☐ Yes ☐ No
Number of pregnancies: _____
☐ Number of children: _____

Skin

C P
☐ ☐ Rashes/itching
☐ ☐ Bruise easy
☐ ☐ Dryness
☐ ☐ Boils
☐ ☐ Hives (allergies)

Muscles & Joints

C P
☐ ☐ Sore/stiff neck
☐ ☐ Low back pain
☐ ☐ Mid back ache
☐ ☐ Painful tailbone
☐ ☐ Shoulder pain
☐ ☐ Arm/forearm pain
☐ ☐ Elbow pain
☐ ☐ Wrists/hand pain
☐ ☐ Hip pain
☐ ☐ Knee pain
☐ ☐ Ankle/foot trouble
☐ ☐ Arthritis
☐ ☐ Loss of strength

Eyes/Ears/Nose/Throat

C P
☐ ☐ Failing vision
☐ ☐ Eye pain
☐ ☐ Failing hearing
☐ ☐ Earache
☐ ☐ Ring/buzz in ears
☐ ☐ Frequent colds
☐ ☐ Sinus infection
☐ ☐ Enlarged thyroid
☐ ☐ Enlarged glands
☐ ☐ Nervousness
☐ ☐ Convulsions

Have you ever had any fractures?
☐ Yes ☐ No
If yes - where?
_____

Have you ever been in a car accident?
☐ Yes ☐ No
If yes - when?
_____

Have you ever been hospitalized?
☐ Yes ☐ No
If yes – why/ when?
_____

Have you ever been diagnosed with:
Cancer ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Hep A/B/C ☐ Yes ☐ No

Have you ever had any mental health issues?

C P
☐ ☐ Depression
☐ ☐ Anxiety
☐ ☐ Nervousness
☐ ☐ Trauma related condition
☐ ☐ Substance related condition
☐ ☐ Personality disorder
☐ ☐ Bipolar disorder
☐ ☐ Other (please list):
_____
_____
_____

Clinician comments and signature:
_____
_____
_____

Please read and sign:

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I understand that the Chiropractor can end treatment at anytime due to inappropriate behaviour.
- I consent to a health assessment/reassessments and chiropractic treatment at Massage Addict.
- I authorize Massage Addict to contact my doctor or other health care professional listed above if required for treatment purposes.
- I understand that all sessions include a pre-health assessment and change time.
- I understand 24 hours notice is required to reschedule all future appointments, or full charges will apply.
- I authorize my health file to be transferred to another Massage Addict clinic if I relocate or a new Massage Addict clinic opens closer to my household.
- Note that the treatment time listed is the maximum time length and actual treatments, based on your specific therapeutic need and treatment plan, may be shorter.

Signature _____ Today's Date _____

Updates to your health history are required every 6 months. A new health history form must be filled out every year.

Changes ☐ Yes ☐ No
Comments _____ Signature_____

Changes ☐ Yes ☐ No
Comments _____ Signature_____