Confidential Adult Patient Health Record

Dr. Rob Murray, 389 Eagle Street, Newmarket, ON, L3Y 1K5 • 905-895-0663

MURRAY
FAMILY CHIROPRACTIC

Personal Information

Name _____ Referred By _____

Address _____ City _____

Postal Code _____ Email _____

Home Phone _____ Cell Phone _____

Date of Birth(Y) _____ / (M) _____ / (D) _____ Gender: ○M ○F Other _____

Your Pronouns ○He/Him/His ○She/Her/Hers ○They/Them/Theirs ○Ze/Hir/Hirs Other _____

Marital Status: Ⓜ Ⓢ Ⓦ Ⓓ Ⓒ Spouse/Partner's Name _____ # of Children _____

Occupation _____ Workplace _____

Reason for consulting our office today _____

_____

Why Providing This Information Is Important

The human body is designed to be healthy. On a daily basis we experience physical, chemical and emotional stressors that can accumulate and result in serious loss of good health. The effects are often gradual and not felt until they become more serious. Our goal is to address the issues that brought you to our office, and offer you the opportunity to improve your overall health.

The Beginning Years (Birth to age 17)

Research is showing that most of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	Yes	No	Unsure	Please provide details:
Did you have any childhood injuries, falls, or car accidents?	○	○	○	
Did you have any childhood illnesses?	○	○	○	
Did you have any concussions? (when, how many)	○	○	○	
Did you ever fall or jump from a height over 3 feet? (i.e. crib, bunk bed, tree)	○	○	○	
Did you play contact sports?	○	○	○	
Did you suffer any other physical or emotional traumas?	○	○	○	
As a child, were you under regular chiropractic care?	○	○	○	

Were you delivered: ○Naturally ○C-Section ○Forceps ○Vacuum ○Medically induced labour ○Unsure

The Adult Years (Age 18 to present)

	Yes	No	Please provide details:
Have you been in any car accidents?	○	○	
Have you had any surgeries or hospitalizations?	○	○	
Do/did you play contact or extreme sports?	○	○	
Have you had any falls or injuries?	○	○	

On a scale of 1-10, please rate your stress level (0 = none, 10 = severe) Occupational: ___/10 Personal: ___/10

For women: As x-rays may be taken, is there a chance you may be pregnant? ○Yes ○No

Please Initial: _____

If you have no specific symptoms or complaints, and are here for **wellness care**, please check here: ☐

Please check off your **symptoms**, past (P) and current (C), even if you don't feel they are related to your problem.

P	C	**Cervical Spine related symptoms:**
☐	☐	Headaches: Type _____
☐	☐	Neck Pain
☐	☐	Shoulder Pain ☐Left ☐Right
☐	☐	Arm pain/numbness ☐Left ☐Right
☐	☐	Hand pain / numbness ☐Left ☐Right
☐	☐	High Blood Pressure ☐Low Blood Pressure
☐	☐	Tinnitus / Ringing in Ears
☐	☐	Earaches
☐	☐	Hearing Loss
☐	☐	Dizziness
☐	☐	Vertigo
☐	☐	Frequent Colds / Flu / Weak Immunity
☐	☐	Seasonal Allergies
☐	☐	Sinus Infections
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Fatigue
☐	☐	Difficulty Sleeping / Insomnia
☐	☐	ADHD / Lack of Concentration
☐	☐	Underactive Thyroid Overactive Thyroid
☐	☐	Persistent Cough / Tickle in Throat

General symptoms:

☐	☐	Arthritis
☐	☐	Fibromyalgia
☐	☐	Osteoporosis
☐	☐	Trouble losing weight
☐	☐	Morning Stiffness / Pain
☐	☐	Stress
☐	☐	Nausea

P	C	**Thoracic Spine related symptoms:**
☐	☐	Mid-Back Pain
☐	☐	Pain Between the Shoulders
☐	☐	Chest Pain
☐	☐	Heart Disease / Palpitations / Arrhythmia
☐	☐	Heartburn / Acid reflux / GERD
☐	☐	Shortness of Breath
☐	☐	Asthma
☐	☐	Bronchitis / Pneumonia
☐	☐	Kidney Infections / Stones
☐	☐	Adrenal Fatigue
☐	☐	Diabetes

Lumbar Spine related symptoms:

☐	☐	Low Back Pain
☐	☐	Sciatica ☐Left ☐Right
☐	☐	Herniated / Bulging Disc(s)
☐	☐	Disc Degeneration
☐	☐	Hip Pain ☐Left ☐Right
☐	☐	IT-Band Tightness / Syndrome
☐	☐	Leg Pain / Numbness ☐Left ☐Right
☐	☐	Knee Pain ☐Left ☐Right
☐	☐	Ankle Pain / Swelling ☐Left ☐Right
☐	☐	Foot Pain ☐Left ☐Right
☐	☐	Irritable Bowel Syndrome
☐	☐	Constipation ☐Diarrhea
☐	☐	UTI / Bladder Infections
☐	☐	Awaken at Night / Frequent Urination
☐	☐	Urinary Incontinence
☐	☐	Menstrual Cramps / Challenges
☐	☐	Sexual Dysfunction

Diagnosed Health Conditions (if not included above): _____

Current Medications: _____

Please describe your primary area of complaint, including the affect it has had on your life: _____

Please mark the intensity of your pain/discomfort on the scale below:

0 (no pain at all) 5 10 (worst pain imaginable)

How long have you had this condition? _____ Is it reoccurring? _____

What relieves it? _____ What makes it worse? _____

Since the problem started, is it: ☐Better ☐Same ☐Worse

Is the pain: ☐Sharp ☐Dull ☐Burning ☐Tight ☐Throbbing ☐Numb ☐Tingling Other: _____

Is this interfering with your: ☐Sleep ☐Work ☐Exercise ☐Sitting ☐Family Other: _____

Names of other Health Care Professionals you have seen for this problem:

Chiropractor _____

Medical Doctor/Other _____

Patient Signature _____ Date _____