

**CONFIDENTIAL PATIENT HEALTH RECORD**

Name: \_\_\_\_\_ Birthdate:    /    /    Gender:  M  F    File No.: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Type of Work: \_\_\_\_\_  
 Circle One: Married    Single    Widowed    Divorced    Separated    Other    Number of Children: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Who may we thank for referring you to this office? \_\_\_\_\_

**CURRENT HEALTH CONDITION**

Current Health Complaint(s): \_\_\_\_\_  
 When did this begin? \_\_\_\_\_  
 Has the condition occurred before?     Yes     No    When? \_\_\_\_\_  
 Is the condition:     Job Related     Auto Related     Home Injury     Fall     Other: \_\_\_\_\_  
 What does it feel like:     Sharp     Dull     Ache     Pins & Needles     Numb     Burning     Other: \_\_\_\_\_  
 Frequency of Pain:     Constant     Intermittent    If intermittent, how often? \_\_\_\_\_  
 How long does each episode last? \_\_\_\_\_ When was your last episode? \_\_\_\_\_  
 Please circle a number below to indicate the severity of your pain:  
    (None)    0    1    2    3    4    5    6    7    8    9    10    (Unbearable)  
 Has the condition been getting:     Worse     Better     Stayed the Same  
 What aggravates the condition? \_\_\_\_\_  
 What makes the condition feel better? \_\_\_\_\_  
 Does your pain radiate anywhere (e.g. into arms or legs)?     Y     N    Where? \_\_\_\_\_  
 What activities are you unable to do because of this condition? \_\_\_\_\_  
 Have you had any previous injuries to the area of your complaint?     Y     N    When? \_\_\_\_\_  
 Have you seen another health professional for this condition?     Y     N    Who? \_\_\_\_\_  
 What previous treatments have you received for this condition? \_\_\_\_\_  
 Previous Chiropractic care?     Y     N    Who? \_\_\_\_\_ Last Visit:    /    /  
 What was your previous Chiropractic care for? \_\_\_\_\_ Did it help?     Y     N  
 Please indicate the level of improvement you expect from Chiropractic treatment of your condition:  
     0%     25%     50%     75%     100%

Please indicate which type of chiropractic care you would like:  
 Relief care - alleviates your symptoms but not the cause  
 Corrective Care - alleviates your symptoms or pain and corrects the cause of the problem  
 Maintenance Care - regular treatment to prevent symptoms from occurring

Patient: \_\_\_\_\_

File No.: \_\_\_\_\_

## SYSTEMS REVIEW

Below is a list of diseases and symptoms which may seem unrelated to the purpose of your appointment. However, it is important that you **check any that you have currently or have had in the past** as these may affect the overall course of your chiropractic care.

### **NERVOUS SYSTEM**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion
- Depression
- Fainting
- Convulsions
- Seizures
- Cold / Tingling (hands/feet)
- Multiple Sclerosis
- Alzheimers
- Dementia
- Other: \_\_\_\_\_

### **MUSCLES/JOINTS**

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Elbow Pain
- Wrist Pain
- Shoulder Pain
- Knee Pain
- Hip Pain
- Foot Pain
- Plantar Fasciitis
- Pain / Clicking Jaw
- Joint Pain / Stiffness
- General Stiffness
- Bone Cancer
- Other: \_\_\_\_\_

### **EARS/NOSE/THROAT**

- Double/Blurry Vision
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Sinus Congestion
- Postnasal Drip
- Nasal Polyps
- Cataracts
- Glaucoma
- Environmental Allergies
- Other: \_\_\_\_\_

### **HEART**

- Chest Pain
- Shortness of Breath
- High / Low Blood Pressure
- Irregular Hear Beat
- Heart Problems
- Varicose Veins
- Ankle Swelling / Edema
- Stroke
- Pacemaker
- Heart Attack
- Bypass Surgery
- Other: \_\_\_\_\_

### **RESPIRATORY**

- Lung Problems
- Pneumonia
- Asthma
- Tuberculosis
- Lung Cancer
- Other: \_\_\_\_\_

### **DIGESTION**

- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps
- Gas / Bloating After Meals
- Heartburn
- Ulcer
- Other: \_\_\_\_\_

### **BOWEL/BLADDER**

- Colitis
- Irritable Bowel Syndrome
- Black / Bloody Stool
- Discoloured Urine
- Painful Urination
- Painful Bowel Movement
- Frequent Urination
- Bowel / Bladder Cancer
- Other: \_\_\_\_\_

### **GENERAL**

- Fatigue
- Medicinal Allergies
- Loss of Sleep
- Fever
- Headaches
- Cancer

### **MALE**

- Prostate Problem
- Sexual Dysfunction
- Breast Pain/Lumps
- Breast Cancer
- Prostate Cancer
- Other: \_\_\_\_\_

### **FEMALE**

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain
- Yeast Infections
- Breast Pain/Lumps
- Breast Cancer
- Endometriosis
- Uterine / Ovarian Cancer
- Other: \_\_\_\_\_

When was your last period?

      /      /

Are you pregnant?  Y  N

Due Date:     /      /

### **INTAKE**

- Coffee
- Tea
- Alcohol
- Cigarettes
- White Sugar

### **DIET**

- Vegetarian
- Lactose Intolerant
- Glutein Intolerant
- Food Allergies
- Other: \_\_\_\_\_

### **LIFESTYLE STRESS**

- High
- Moderate
- Little

Patient: \_\_\_\_\_

File No.: \_\_\_\_\_

## HEALTH HISTORY

Current Family Doctor: \_\_\_\_\_ Approximate Date of Last Physical Exam: / /

Current Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Any recent weight:  Loss  Gain How much? \_\_\_\_\_

Please indicate if you have had any surgeries/operations/hospitalizations:

- Appendix  Tonsils  Gall Bladder  Hernia  Back Surgery  Broken Bones: \_\_\_\_\_
- Other: \_\_\_\_\_

Have you had any previous:

- Childhood Traumas: \_\_\_\_\_ When? \_\_\_\_\_
- Sports Injuries: \_\_\_\_\_ When? \_\_\_\_\_
- Auto-accidents: \_\_\_\_\_ When? \_\_\_\_\_
- Work Injuries: \_\_\_\_\_ When? \_\_\_\_\_

Do you have any medical conditions: \_\_\_\_\_

Are you currently taking any medications or supplements: \_\_\_\_\_

Have you had any of the following done in the last six months:  X-ray  Ultrasound  MRI  CT scan

Have you had any blood work done in the last year?  Y  N If yes, why? \_\_\_\_\_

Is there any member of your family who has the following:

- Diabetes  Cancer  Arthritis  Stroke  Neurological Disorder  Blood Pressure Problem
- Heart Problem  Seizures/Convulsions  Similar Condition To Your Current Complaint

Check any of the following diseases you have had or currently have:

- |  |                                  |                                      |                                    |                                   |
|--|----------------------------------|--------------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Cancer    | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Mumps   | <input type="checkbox"/> Small Pox   | <input type="checkbox"/> Thyroid   | <input type="checkbox"/> Eczema   |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> HIV     | <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Influenza | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> AIDS    | <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Pleurisy  |                                   |

Do you smoke?  Y  N  Quit: how long? \_\_\_\_\_ If smoke, how many packs/day? \_\_\_\_\_ For how long? \_\_\_\_\_

How many hours of sleep do you get a night? \_\_\_\_\_ Do you feel rested when you wake up?  Y  N

What position do you sleep in?  Side  Back  Stomach

How old is your mattress and pillow? \_\_\_\_\_

How often do you exercise?  Daily  Every other day  Weekly  Infrequent  None

Are there any other conditions that you suffer that you would like Dr. McGlashan to address?  Y  N

Doctor's Notes (please leave this box blank):

Date: / /

Verbal ROF:  Y  N

X-Rays:  Y  N  Other: \_\_\_\_\_

Pt. Accepted:  Y  N  Referred: \_\_\_\_\_ Signed: \_\_\_\_\_

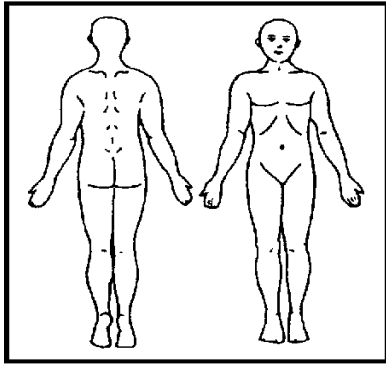
Patient: \_\_\_\_\_

File No.: \_\_\_\_\_

## PHYSICAL EXAMINATION

### Posture/Observation

- Bruising
- Swelling
- Cuts/Scars
- Rash
- Other:



Arches:  Low  Normal  High  R  L  B  
 Head Carriage:  Mild  Mod.  Severe  A  P

### Neurological Exam

Reflexes Upper: Lower:

Motor Upper: Lower:

Sensory Light:

Other:

### Orthopedic Testing

### Range of Motion

Active/Passive:

Resisted:

### Joint / Muscle Palpation

R

C1 2 3 4 5 6 7 T1 2 3 4 5 6 7 8 9 10 11 12 L1 2 3 4 5 SI

L

Other:

### Doctor's Comments

DDX:

Prognosis:

Risks:

Benefits:

Other:

Current Dx.: \_\_\_\_\_

### Treatment:

- Spinal Adjustment  Extremity Adjustment  Joint Mobilization  Thumper  Soft Tissue Therapy/Trigger Point Therapy
- Ultrasound  IFC  In-office Stretching  Ice or Heat  Home exercises  Home Ice or Heat  Acupuncture
- Other:

Frequency:  1x/wk  2x/wk  3x/wk  1x/2wks  1x/3wks  1x/month  Other:

Total Tx. Before Next Re-evaluation: \_\_\_\_\_