



CONFIDENTIAL HEALTH HISTORY FORM

Dear New Patient,

Please complete the following questionnaire as fully and carefully as possible. Your answers will help us to process your file, determine the nature of your complaint, and decide how best to assist you. This information will remain strictly confidential.

PERSONAL INFORMATION

Date: _____

| | | | | | | |
|--|--------------------------|-----------------------------------|---------------------|----------------------------|-----------|-----------|
| Last Name _____ | | First Name _____ | | D.O.B. (mm/dd/yy) _____ | Age _____ | M/F _____ |
| Mailing Address _____ | | City _____ | Province _____ | Postal Code _____ | | |
| Home Telephone _____ | Business Telephone _____ | Other (cell phone) _____ | Email Address _____ | | | |
| Occupation _____ | Doctor's Name _____ | Doctor's Location & Phone # _____ | | Date of Last Medical _____ | | |
| How were you referred to our clinic? _____ | | | | | | |

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

To be filled out by Guardian if patient is under 18 years of age.

Parent's Name _____ Work Number _____

I hereby authorize and consent for Align Health Centre to evaluate and care for my child

Parent / Guardian Signature _____ Date _____

CURRENT HEALTH STATUS

What are you seeking treatment for? _____

Was this a motor vehicle accident (MVA) or a workplace injury? Yes No

How long has the condition been bothering you? _____

Have you ever undergone advanced imaging (CT scan, x-ray, MRI) for the condition? Yes No

If yes, when and where? _____

Have you ever sought other treatment for this condition? Yes No For any other condition / concern? Yes No

- Chiropractic care (Practitioner's name) _____
- Massage Therapy (Practitioner's name) _____
- Naturopathic Doctor (Practitioner's name) _____
- Acupuncturist (Practitioner's name) _____
- Physiotherapy (Practitioner's name) _____
- Medical Doctor (Practitioner's name) _____
- Other (please specify) _____

Are there any other conditions you would like to discuss? _____

Please list all medications and supplements you are currently taking and indicate the reason for use:



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MEDICAL HISTORY

Please indicate which of the following you are currently experiencing or have experienced in the past by writing (where applicable) **C** (for current) or **P** (for past)

| | | | | | |
|---|--|--|--|---|--|
| <p>CARDIOVASCULAR</p> <ul style="list-style-type: none"> <input type="checkbox"/> Stroke <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Circulatory Disorders <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Pacemaker <input type="checkbox"/> Phlebitis <input type="checkbox"/> Heart Disease <input type="checkbox"/> Chronic Congestive Heart Failure <input type="checkbox"/> Myocardial Infarction | <p>RESPIRATORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Emphysema <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Bronchitis <input type="checkbox"/> Breathing Difficulty <input type="checkbox"/> Lung Disorder | <p>NEUROLOGICAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Neuritis <input type="checkbox"/> Other _____ | <p>DIGESTIVE & URINARY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic Abdominal Pain <input type="checkbox"/> Prolonged Constipation <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Diarrhea <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Gastritis <input type="checkbox"/> Liver / Gall Bladder <input type="checkbox"/> Kidney / Bladder | | |
| <p>SKIN</p> <ul style="list-style-type: none"> <input type="checkbox"/> Easily Bruise <input type="checkbox"/> Eczema / Psoriasis <input type="checkbox"/> Rash <input type="checkbox"/> Cold Sores / Warts <input type="checkbox"/> Herpes <input type="checkbox"/> Athlete's Foot <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Skin Conditions _____ | <p>HEAD & NECK</p> <ul style="list-style-type: none"> <input type="checkbox"/> Headache <input type="checkbox"/> Migraine <input type="checkbox"/> Visual Disturbances <input type="checkbox"/> Earaches <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Teeth / Jaw Pain <input type="checkbox"/> Locked Jaw <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Injury <input type="checkbox"/> Dizziness / Vertigo | <p>SOFT TISSUE & JOINT Complaints</p> <p>L R</p> <ul style="list-style-type: none"> <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Upper Back <input type="checkbox"/> Mid Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Hip <input type="checkbox"/> Leg <input type="checkbox"/> Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Other _____ | <p>FEMALE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Menstrual Problems <input type="checkbox"/> Pregnant: Term _____ <input type="checkbox"/> Menopausal Problems <input type="checkbox"/> Endometriosis <input type="checkbox"/> Previous C-Section <p>MALE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Haemorrhoids <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Sexual Dysfunction <input type="checkbox"/> Hernias | | |
| <p>OTHER</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> HIV / AIDS <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Allergies </td> <td style="width: 50%; vertical-align: top;"> <ul style="list-style-type: none"> <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Insomnia <input type="checkbox"/> Fainting <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Seasonal Affective Disorder <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Scoliosis <input type="checkbox"/> Haemophilia </td> </tr> </table> <p>LIFESTYLE CHECKLIST</p> <ul style="list-style-type: none"> <input type="checkbox"/> Exercise regularly _____ x / week <input type="checkbox"/> Consume caffeine _____ x / week <input type="checkbox"/> Consume alcohol _____ x / week <input type="checkbox"/> Smoke _____ x / week | | <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> HIV / AIDS <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Allergies | <ul style="list-style-type: none"> <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Insomnia <input type="checkbox"/> Fainting <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Seasonal Affective Disorder <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Scoliosis <input type="checkbox"/> Haemophilia | <p>INJURIES</p> <ul style="list-style-type: none"> <input type="checkbox"/> Muscle Strain _____ <input type="checkbox"/> Ligament Sprain _____ <input type="checkbox"/> Fracture _____ <input type="checkbox"/> Whiplash _____ <input type="checkbox"/> Herniated Disc _____ <input type="checkbox"/> Other: _____ | <p>SURGICAL IMPLANTS</p> <p>Pins, plates, wires, artificial joints:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Other:</p> <p>_____</p> <p>_____</p> <p>_____</p> |
| <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> HIV / AIDS <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hepatitis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Allergies | <ul style="list-style-type: none"> <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Insomnia <input type="checkbox"/> Fainting <input type="checkbox"/> Chronic Fatigue Syndrome <input type="checkbox"/> Seasonal Affective Disorder <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Scoliosis <input type="checkbox"/> Haemophilia | | | | |



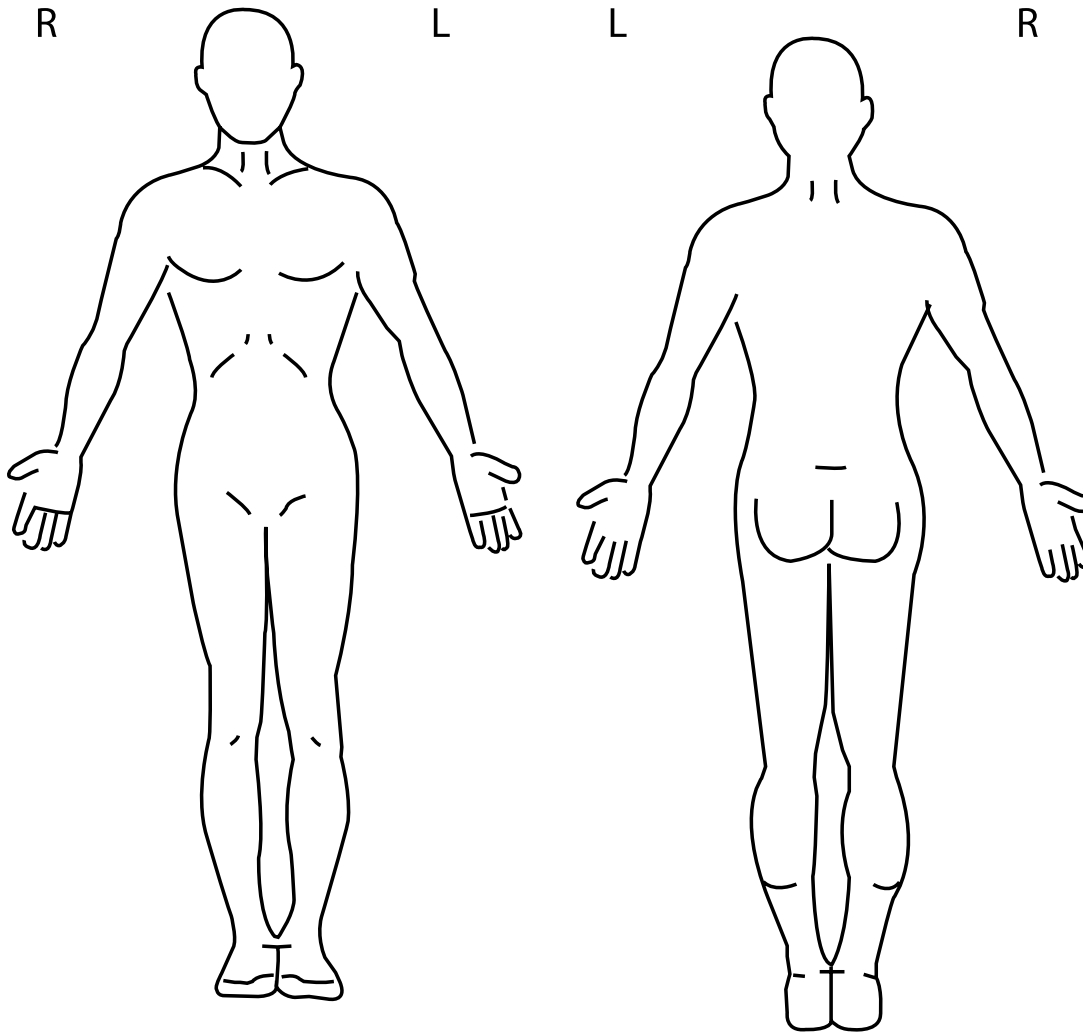
PAIN DIAGRAM

| | |
|---|------------|
| Name _____ | Date _____ |
| How long have you had pain _____ Years _____ Months _____ Weeks | |

In the diagram 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. Also, in order to complete the picture, please draw your face.

SYMBOLS:

- | | | | |
|---------------|--------------------------|------------------|--------------------------|
| Numbness | ===== | Pins & Needles | |
| Burning | XXXXXXXXXX XXXXXXXXXX | Stabbing & Sharp | OOOOOOOOOO OOOOOOOOOO |
| Dull & Aching | +++++++ +++++++ | Stiff & Tight | 2222222222 2222222222 |



VISUAL PAIN ANALOG SCALE INSTRUCTIONS

Make a mark (/) along the line which you think represents your current level of pain in your major area of injury, somewhere between "no pain at all" and "pain as bad as it could be"





PRIVACY CONSENT

PRIVACY CONSENT DOCUMENT

I understand that in signing this document I am giving permission to Align Chiropractic to obtain and keep on file my personal information that I have provided to them. I understand that the personal information provided will not be publicly published without prior consent. The private information may include, but is not limited to:

- Personal data
- Personal health history
- Personal treatment of data and outcome
- Financial information

I understand that Align Chiropractic may use and disclose information in order to:

- Communicate with me in a timely and effective manner
- Communicate with insurance companies with consent
- Assist with my care with other health care professionals
- Efficiently operate a Chiropractic and Health Care Clinic
- Prepare and mail documents to me, as appropriate

I understand that as a patient of Align, I have the following rights concerning my privacy:

- I have the right to know why an organization or individual collects, uses or discloses my personal information
- I have the right to expect an organization to handle my information reasonably and to not use it for any other purpose than the one to which I consented
- I have the right to expect an organization to protect my information from unauthorized disclosure
- I have the right to ensure the identification information an organization holds about me is accurate, complete and current
- I have the right to expect an organization to destroy my identification information when requested or when no longer required for the intended original purpose (except when destruction is not allowed by law, or for insurance purposes or allowed under the College of Chiropractors of Ontario or other governing body)
- I have the right to confidentially complain to an organization about how it handles my identification information and may escalate my complaint to the Privacy Commissioner of Canada, if need be
- I have the right to remove my consent at any time by contacting Align in writing

I understand that Align will not

- Sell my information to anyone without prior consent
- Share my information with organizations outside of our normal relationship that would use it to contact me, the patient about their own products or services without prior consent.

I, the undersigned, understand and consent to this document under the Privacy Act.

Patient Name

Patient Signature

Date

Clinical Staff Signature