



FREDERICTON'S HEALTH SOURCE

Name: _____ Today's Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Date of Birth: _____ Age: _____ Gender: Male Female

Phone: (H) _____ (C) _____ (W) _____

Email: _____

Best way to contact you should we need to: Phone (H/C/W) Email

Job Title: _____ Employer: _____

Marital Status: Single Married Widowed Other

Who can we thank for referring you to our practice? _____

In case of an emergency, whom should we contact?

Name: _____ Relation: _____

Phone Number: _____

Will you be using Insurance to cover the cost of your treatments at our clinic: Yes No

If you do have insurance and would like us to direct bill your insurance company, if so please give your card to the front desk so we may make a copy and keep it on file.

Reason (s) for consult this office: _____

Is this from a motor vehicle accident: Yes No or a work injury/accident: Yes No

Prior Chiropractic care:

Name: _____ Approx. date of last adjustment: _____

Approx. Number of treatments: _____ Results: Excellent Good Fair Very Poor

Prior Massage Care:

Name: _____ Approx. date of last Massage: _____

Approx. Number of treatments: _____ Results: Excellent Good Fair Very Poor

Medical Doctor:

Name: _____ Date of last visit: _____

Was it for the same issue(s) you currently have? Yes No



Health History

What are your Health/Wellness goals? _____

Rank your health out of 10 (10 being excellent): Currently ___/10 Ideally ___/10

What do you hope to accomplish here? _____

Location:

Current Chief Complaint and its location: _____

Time and Duration:

How often do you experience this pain? _____ Constant _____ Frequent _____ Intermittent

What caused the onset? _____

Date of onset: _____

Severity:

On a scale of 0 to 10 with 0 representing no pain and 10 being the most severe pain imaginable, please rate the severity of your pain:

Sitting here today, right now, what is the intensity of your pain on a scale of 0 to 10? _____

What is the least intense the symptom has been on a scale of 0 to 10? _____

What is the most intense the symptom has been on a scale of 0 to 10? _____

Associated Signs/Symptoms:

Please check all that apply · _____ Inflexibility _____ Stiffness _____ Spasms _____ Cramps

Does this pain travel or radiate anywhere? (if Yes, where) _____

Quality:

How would you best describe the sensation of the pain/symptom:

_____ Sharp _____ Stabbing _____ Aching _____ Pins & Needles _____ Pounding _____ Shooting

_____ Burning _____ Dull _____ Tingling/Numb _____ Throbbing _____ Crawling _____ Stinging

Modifying Factors:

What aggravates the pain/symptom?

_____ Sneezing _____ Lifting _____ Exercising _____ Looking up/down _____ Walking _____ Driving

_____ Coughing _____ Sitting _____ Bending _____ Looking side/side _____ Standing _____ Stress

_____ Climbing Stairs _____ Getting out of bed _____ Repetitive movement _____ Getting in/out of car

Other: _____

What relieves this pain/symptom?

_____ Resting _____ Sleeping _____ Exercising _____ Looking up/down _____ Shower

_____ Advil _____ Stooping _____ Bending over _____ Mineral Ice

_____ Other: _____

Over the past weeks/months this complaint is: _____ Improving _____ Getting worse _____ About the same

Have you seen anyone for this condition? _____ YES _____ NO WHOM? _____



Chief Complaint

Mark the areas on this body where you feel the described sensation. Use the appropriate symbols and use all that may apply.

Numbness - NNNNNNNNNNNNNNN

Burning – BBBBBBBBBBBBBBBBBBB

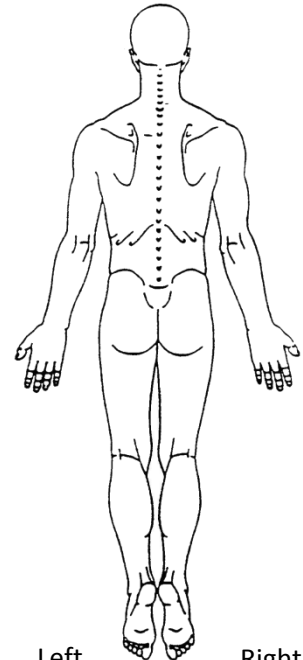
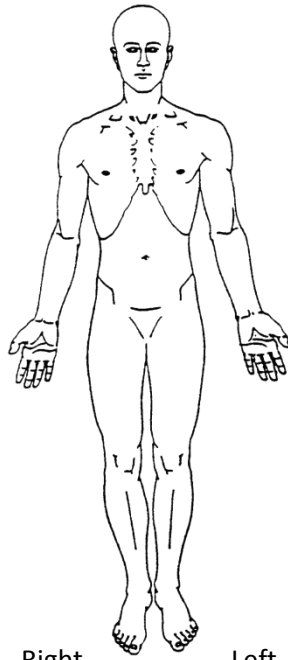
Dull – DDDDDDDDDDDDDDDDDDD

Sharp/ Stabbing – SSSSSSSSSSSSS

Tingling (Pins and Needles) – TTTTTT

Achy/Stiff - AAAAAAAAAAAAAAAAA

Do you have any internal pins, wires or artificial joints? If so, what and where?



Please check the appropriate box(s) for any of the following symptoms you may have (NP=Not Present; P=Present).

Muscle and Joint

- | | | |
|--------------------------|--------------------------|---------------|
| NP | P | |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Bursitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Hernia |
| <input type="checkbox"/> | <input type="checkbox"/> | Low back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbows |

Eyes, Ears, Nose, Throat

- | | | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Colds |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma/Wheezing |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear aches/Infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus Infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore throat |

- | | | |
|--------------------------|--------------------------|----------------|
| NP | P | |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of Sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervousness |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruise easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Hives/Itching |
| <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Twitching Eyes |

Cardio-Vascular

- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Fast Heart Beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Slow heart beat |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor circulation |
| <input type="checkbox"/> | <input type="checkbox"/> | low blood pressure |

Genito-Urinary

- | | | |
|--------------------------|--------------------------|--------------------|
| NP | P | |
| <input type="checkbox"/> | <input type="checkbox"/> | Bed wetting |
| <input type="checkbox"/> | <input type="checkbox"/> | Kidney Infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination |

Digestive System

- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Excess hunger |
| <input type="checkbox"/> | <input type="checkbox"/> | Burping/Gas |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficult digestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation |

Pain/Numbness

- | | | |
|--------------------------|--------------------------|-------------|
| NP | P | |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulders |
| <input type="checkbox"/> | <input type="checkbox"/> | Arms/hands |
| <input type="checkbox"/> | <input type="checkbox"/> | Hips/Legs |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankles/feet |
| <input type="checkbox"/> | <input type="checkbox"/> | Sciatica |

(Woman Only)

- | | | |
|--------------------------|--------------------------|-----------------|
| NP | P | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | Heavy Flow |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular cycle |
| <input type="checkbox"/> | <input type="checkbox"/> | Miscarriages |

Are You pregnant? _____

Due Date: _____

Do you have a pacemaker? _____



FREDERICTON'S HEALTH SOURCE

PLEASE LIST PAST SURGERIES:

1. _____ Year _____ 2. _____ Year _____
 3. _____ Year _____ 4. _____ Year _____

List any key slips, falls or MV accidents you've had from childhood to present (Including Date)

- 1) _____
 2) _____
 3) _____

What medications, birth control are you currently taking? (Include Date)

- 1) _____ 2) _____
 3) _____ 4) _____
 5) _____ 6) _____

Do you have any Allergies? _____

What Vitamins are you currently taking? _____

LIFESTYLE

Number of Children: _____ Children's Name(s): _____

Frequency of Exercise: ___ Never ___ Rarely ___ Occasionally ___ Moderately ___ Regularly

Intensity of Exercise: ___ Low Level ___ Medium Level ___ High Level ___ Competition Level

Types of exercise you enjoy: _____

Sufficient Rest: ___ Never ___ Rarely ___ Occasionally ___ Moderately

Hours of Sleep: ___ 4 ___ 6 ___ 8 ___ 10 ___ More than 10

Well balanced diet: ___ Never ___ Rarely ___ Occasionally ___ Moderately

How many glasses of water per day do you drink? _____

Do you smoke (per day)? ___ No ___ Occasionally ___ 1 to 2 ___ 2 to 3 ___ 4 to 5 ___ 1+packs/day

Do you drink caffeinated beverages?(per day) ___ No ___ Occasionally ___ 1 to 2 ___ 2 to 3 ___ 4 to 5

Do you drink alcoholic beverages? ___ No ___ Occasionally ___ 1 to 2 ___ 2 to 3 ___ 4 to 5 ___ More

Have you ever used street drugs? ___ Yes ___ No

Hobbies: _____

Current Stress

Rank your current level of Personal stress? ___ Very low ___ Moderate ___ Very High

Rank your current level of Physical Stress? ___ Very Low ___ Moderate ___ Very High

Rank your current level of Chemical stress (Processed food, Medications, etc) ___ Low ___ Moderate ___ High

Rank your current level of Career Stress? ___ Very Low ___ Moderate ___ Very High

Rank your current level of Emotional stress? ___ Very Low ___ Moderate ___ Very High

Anything that you would like to add to help us give you the best possible care? _____



FOR MASSAGE and FASCIAL STRETCH PATIENTS: (please initial the following indicating you understand the health forms you filled out and grant permission to have your health care evaluated and to receive massage therapy)

1. (For Massage appointments) I am aware that draping will be used during the massage _____
2. I understand my feedback is an essential element in my treatment and therefore if at any time I should become uncomfortable during the session, I may bring it to my therapist attention _____
3. If I am unable to keep an appointment , I understand **24 hours' notice is required** to change the time otherwise I will be charged for the session that I have reserved _____
4. Payment is required in full at each visit _____

I have read and full understand this for in its entirety. If at any time there are changes in the information given or in my condition, I will notify my therapist. The treatment(s) given here is for the sole purpose of stress reduction, relief from muscle tension of spasm and to increase circulation and energy flow.

The therapist does not diagnose or prescribe for mental illness, disease or any other physical or mental disorder. The massage therapist does not perform spinal manipulations. Massage Therapy or Fascial Stretch Therapy is not a substitute for medical examination or diagnosis and it is recommended that a physician be seen.

It is the Client's (your) responsibility to explain and discuss all physical conditions with the therapist so that they may do their job.

Client Signature: _____ Therapist signature: _____
Date: _____

FOR CHIROPRACTIC PATIENTS: (please initial the following indicating you understand the health forms you filled out and grant permission to have your health care evaluated)

1. If I am unable to keep an appointment , I understand **24 hours' notice is required** to change the time otherwise I will be charged for the appointment that I have reserved _____
2. Payment is due in full at the time of service. If you wish to have your insurance direct billed please give your insurance card to the front desk _____

Our goal at Fredericton's Health Source is to provide you with exceptional, detailed assessment of your health. We want to provide you the resources for superior care and get your body back to its absolute peak potential.

I consent to a Chiropractic, Neurologic and Orthopedic evaluation and grant permission to receive the evaluation that includes this history. Any findings will be communicated to me before treatment and will remain confidential between myself and my Doctor.

Consenting Signature: _____ Doctor Signature: _____
Date: _____