



DATE

**PERSONAL HISTORY**

Title: Dr  Mr  Mrs  Miss  Ms  Address: \_\_\_\_\_

Name: \_\_\_\_\_

Home ☎: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Mobile ☎: \_\_\_\_\_ Marital Status \_\_\_\_\_

Business ☎: \_\_\_\_\_ Ages of Children: \_\_\_\_\_

E-mail: \_\_\_\_\_

Current Occupation: \_\_\_\_\_

Employer/Company: \_\_\_\_\_

How did you hear about Fitzwilliam Health Clinic? \_\_\_\_\_

Name of Doctor & contact details: \_\_\_\_\_

**CURRENT HEALTH CONDITION**

Purpose of this appointment: \_\_\_\_\_

When did this condition begin? \_\_\_\_\_ Has this condition occurred before? Yes  No

Is the condition: Job Related  Car Accident  Home Injury  Fall  Other  \_\_\_\_\_

Have you had any previous treatment for this condition: Yes  No  With Whom: \_\_\_\_\_

Type of treatment: \_\_\_\_\_ Results: \_\_\_\_\_

Please list any medication and/or vitamins/supplements you are taking?: Nerve Pills  Pain Killers

Muscle relaxants  Blood Pressure Medicine  Insulin  Other \_\_\_\_\_

Please list any conditions under current medical care: \_\_\_\_\_

Do You Intake: Cigarettes  Per Day? \_\_\_\_\_ Alcohol  Units per Week? \_\_\_\_\_ Caffeine  \_\_\_\_\_

**PAST HEALTH HISTORY**

Major Surgery/Operations:

Appendectomy  Tonsillectomy  Gall Bladder  Hernia  Back Surgery  Knee Surgery

Pelvic Surgery  Other  \_\_\_\_\_

Please list any past accidents/falls \_\_\_\_\_

Please list any fractures/ dislocations \_\_\_\_\_

Please list any visits to hospital (other than above): \_\_\_\_\_

Date of last physical examination by doctor: \_\_\_\_\_

Have you previously had Chiropractic care: Yes  No

Doctor's name & approximate date of last visit: \_\_\_\_\_

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.

**HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?:**

- |  |                                      |                                    |                                  |   |
|--|--------------------------------------|------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Mumps       | <input type="checkbox"/> Influenza | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Eczema         |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox   | <input type="checkbox"/> Pleurisy  | <input type="checkbox"/> Asthma  | <input type="checkbox"/> Measles        |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anaemia | <input type="checkbox"/> Heart Disease  |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> Cancer  | <input type="checkbox"/> Whooping Cough |

**DETAILS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you been tested HIV positive?  Yes  No

**HAVE YOU HAD ANY OF THE FOLLOWING IN THE PAST 6 MONTHS:**

**MUSCULO-SKELETAL**

- Low Back Pain
- Pain Between Shoulders
- Neck Pain
- Arm Pain
- Joint Pain or Stiffness
- Leg pain
- Walking Problems
- Difficulty Chewing or Clicking Jaw
- General stiffness

**NERVOUS SYSTEM**

- Nervous
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion or Depression
- Fainting
- Convulsions
- Cold or Tingling Extremities
- Stress

**GENERAL**

- Fatigue
- Allergies
- Loss of Sleep
- Fever
- Headaches
- Hayfever

**GASTRO-INTESTINAL**

- Poor or Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhoea
- Constipation
- Haemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Problems

Abdominal Cramps

- Gas or Bloating After Meals
- Heartburn
- Black or Bloody Stool
- Colitis

**GENITO-URINARY**

- Bladder Trouble
- Painful or Excessive Urination
- Discoloured Urine
- Urinary Tract Infection

**CARDIOVASCULAR**

- Chest Pain
- Short Breath
- Blood Pressure Problems
- Irregular Heartbeat
- Heart Problems
- Lung Problems or Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

**EARS-NOSE-THROAT**

- Vision Problems
- Dental Problems
- Sore Throat or Throat Problems
- Ear Aches
- Hearing Difficulty
- Stuffed Nose
- Sinus Problems

**MALES**

- Prostate/ or Sexual Dysfunction

**FEMALES**

- Menstrual Irregularity
- Menstrual Cramps
- Breast Pain/ or Lumps

What was the date of your last period?

\_\_\_\_\_

Are you pregnant?

Yes  No  Not Sure

**FAMILY HISTORY**

Do any of the following members of your family have any similar problems?

- Mother
- Father
- Brother
- Sister
- Spouse
- Child

***Please outline on the diagram the area of your discomfort***

