HARMONY
Chiropractic Clinic

Dr. Harmony Mir. BMUS, DC

HEALTH HISTORY QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your answers will be held absolutely confidential. If you have any questions, please ask. Thank you.

NAME:_____ Date:_____

Address:_____ City:_____ Prov:_____ PC:_____

Home Tel #: (____)_____ Work/Cell Tel #: (____)_____ Birth date: ___/___/___ Age:____
D M Y

Occupation:_____ Employer:_____

Email address:_____ *office records only

Who may we thank for referring you? _____

Emergency contact: _____ Ph #:_____

Number of children and ages:_____

Medical Doctor:_____ Ph#:(___)_____ Date of last physical:_____

Have you ever received Chiropractic care? YES___ NO___ Date of last adjustment:_____

CARE CARD HEALTH CARE #:_____

DO YOU HAVE **EXTENDED HEALTH CARE** COVERAGE? YES___ NO___

We want to provide you with the best possible health care. To do this, we will first need to understand what you want. Please mark the one that most closely reflects your health care objectives:

_____ **WELLNESS** – I want to build my inner strength. I am conscious about my heath, diet, exercise etc and actively pursue these because I feel better, perform better and it maximizes my potential

_____ **TREATMENT ONLY** – I only consult a health practitioner when I have an ache or pain and etc and discontinue care when It has cleared up.

Motor Vehicle accident(s):_____ ICBC Claim#:_____

MAJOR COMPLAINT:_____
Other injuries:_____ WCB Claim#:_____

This condition interferes with:____ work____sleep____routine____other

HEALTH HISTORY

SYMPTOMS: (**Please circle** any symptoms that you have experienced within the past 6 months)

Headaches	Pins & needles in legs	Loss of smell
Neck pain	Pins & needles in arms	Loss of taste
Sleeping problems	Shortness of breath	Nausea
Back pain	Fatigue	Feet cold
Nervousness	Depression	Cold Sweats
Irritability	Light bothers eyes	Chest pains
Dizziness	Fainting	Ears ring
Blurred vision	Gas, bloating, indigestion	Loss of memory
Loss of balance	Upset stomach	

STRESSORS:

Any experience that overwhelms your physical, emotional, nutritional and/or chemical balance may cause vertebral Subluxation/ Nervous system Interference. Help us understand your accumulative health status by placing a **check mark** the appropriate below

PHYSICAL

_____ Injuries	_____Surgery	
_____ I was active as a child	_____Poor posture	_____ I feel flexible
_____ Physical stress	_____Work injuries	_____ I feel muscle aches frequently
_____I do regular stretching	_____Repetitive tasks at work	
_____ I exercise	_____I do strength training	

_____Family history of disease(s) _____

EMOTIONAL

_____ Single parent family	_____ Abused	_____ Moved a lot
_____ Stressful job	_____ Mental stress	_____ English as a second language
_____ Frequent travel	_____ Take vacations	_____ Awaken rested
_____ Periods of depression		

NUTRITIONAL

_____ Irregular eating habits	_____ Balanced diet	_____ Alcohol use
_____ Food cravings	_____ Caffeine	_____ 8 – 10 glasses of water a day

_____ Supplements_____

CHEMICAL

_____ I smoke	_____ Parents smoke	_____ Vaccinations
_____ I work with chemicals	_____ I have allergies	_____ Many courses of antibiotics

_____ Prescription medications_____

If there is any other information regarding your health status that you think would help us, please mention below:

_____

I believe my commitment to health is:

NOT IMPORTANT 1 2 3 4 5 6 7 8 9 10 UTMOST IMPORTANCE

SYMPTOMS OF PRESENT CONDITION(S):

Mark the area(s) on the diagram where you feel the described sensations.

Please include all affected areas including regions of radiating pain, numbness and tingling.

Please use the following symbols:
XXXXX – sharp pain
OOOO – dull, aching
/////// - numbness or pins & needles