CONFIDENTIAL PATIENT CASE HISTORY FORM

PLEASE PRINT

NAME: _____

BIRTH DATE: DAY _____ MONTH _____ YEAR _____ AGE:_____ SEX: ☐M ☐F

ADDRESS: _____ TOWN/CITY: _____

POSTAL CODE: _____ PHONE (H): _____ PHONE (W): _____

CELL: _____ EMAIL: _____

OCCUPATION: _____

EMERGENCY CONTACT: _____ PHONE: _____

NAME OF FAMILY PHYSICIAN: _____ PHONE: _____

How did you hear about our clinic? _____

Current Complaint(s):_____

_____

When did it start? _____

What was the cause? _____

I would describe the pain as: ☐ Sharp ☐ Dull ☐ Throbbing
☐ Numb ☐ Achey ☐ Shooting ☐ Stiffness ☐ Burning
☐ Tingling ☐ Cramping ☐ Other _____

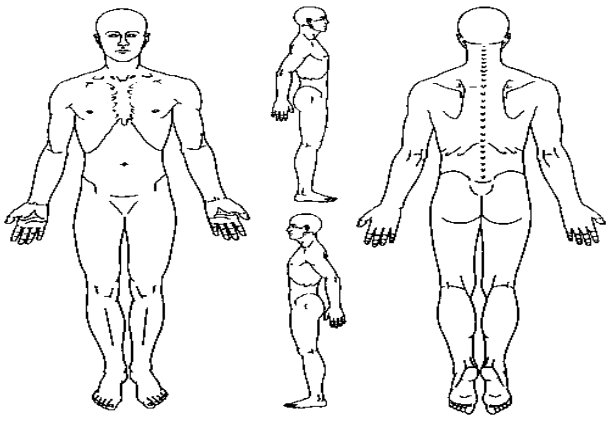
Is the pain ☐ Constant OR ☐ Intermittent

Circle a number to indicate the average intensity of the pain:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain)

Mark the location(s) of your pain on the diagram:

Right Left Left Right



Doctor's Notes

Dr. Wes Dawkins
307 Wellington St., Sarnia, ON N7T 1H4
519.383.6655

File #:_____

What aggravates your condition? ☐ Sitting ☐ Standing
☐ Bending ☐ Lifting ☐ Walking ☐ Cold ☐ Dampness
☐ Laying down ☐ Other:_____

What relieves your condition? ☐ Bed rest ☐ Massage
☐ Ice ☐ Heat ☐ Medication ☐ Other_____

Is the condition getting:
☐ Better ☐ Worse ☐ Same ☐ Recurring (off & on)

Have you been treated for this episode? ☐ Yes ☐ No

If so, what type of treatment? _____

_____

Results: _____

Have you ever had a similar problem? ☐ Yes ☐ No

If so, when?_____

Have you had any special tests or imaging done for this condition? (x-ray, MRI, blood work, etc). If so, what were the results?

_____

_____

Is the condition interfering with your work, activities, sports, hobbies or household chores? If so, which ones? _____

_____

Do you have any other ongoing health conditions? _____

_____

_____

Is your condition a result of an auto accident? ☐ Yes ☐ No

Did you condition start because of or at work? ☐ Yes ☐ No

Have you ever had any major car accidents or falls? If so, when?

_____

_____

Have you been to a chiropractor before: ☐ Yes ☐ No

Doctor: _____ Date of last visit: _____

Doctor's Notes

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307 Wellington, Sarnia, ON, N7T1H4

File #:_____

General Systems Review

(Please select any items that relate to your condition or body)

General
- □ Recent Sudden Weight Loss
- □ Night sweats, fever or chills
- □ New severe headache
- □ Pain that wakes at night
- □ Recent bladder or bowel dysfunction

Family History of
- □ Arthritis
- □ Cancer
- □ High blood pressure
- □ Diabetes
- □ Heart disease
- □ Stroke
- □ Other: _____

Muscle, Joints and Bones
- □ Arthritis
- □ Muscle cramps
- □ Osteoarthritis
- □ Osteoporosis
- □ Rheumatism
- □ Scoliosis
- □ Fibromyalgia
- □ Swollen joints
- □ Warm joints
- □ Other: _____

Lungs and Respiratory
- □ Asthma
- □ Pneumonia
- □ Bronchitis
- □ Difficult or painful breathing
- □ Tuberculosis
- □ Emphysema
- □ Other: _____

Head and Neck
- □ Headaches
- □ Hearing problems
- □ Ringing in the ears
- □ Sound sensitivity
- □ Vertigo
- □ Dizziness
- □ Jaw pain
- □ Visual problems
- □ Double Vision
- □ Tearing
- □ Insomnia
- □ Blurred vision
- □ Light sensitivity
- □ Other: _____

Heart and Circulatory
- □ Ankle swelling
- □ Chest pain
- □ Angina
- □ Leg cramps
- □ Blood pressure high/low
- □ Phlebitis
- □ Heart attack
- □ Stroke
- □ Shortness of breath
- □ Rheumatic fever
- □ Anemia
- □ Varicose Veins
- □ Other: _____

Neurological
- □ Epilepsy
- □ Convulsions
- □ Fainting
- □ Numbness
- □ Sciatica
- □ Stroke
- □ Seizures
- □ Tingling
- □ Tremors

Stomach and Digestion
- □ Appetite loss
- □ Black Stool
- □ Blood in Stool
- □ Constipation
- □ Chron's
- □ Colitis
- □ Diarrhea
- □ Heart Burn
- □ Nausea
- □ Gall Bladder Problem
- □ Gas and Bloating
- □ Irritable Bowel Syndrome
- □ Stomach Cramps
- □ Ulcers

Urinary
- □ Bladder or kidney infections
- □ Blood in urine
- □ Burning
- □ Pain urinating
- □ Difficulty urinating
- □ Incontinence (leakage)
- □ Kidney Stones
- □ Yeast Infection

Female Only
- □ Pregnant - Due Date:
- □ Birth Control Pills
- □ Hysterectomy
- □ Menopause
- □ PMS
- □ Irregular Periods
- □ Painful Cycle
- □ STD

Male Reproductive
- □ Prostate Problems
- □ STD
- □ Trouble with Urination

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File #:_____

Miscellaneous

- ☐ Diabetic
- ☐ Thyroid dysfunction
- ☐ Psoriasis
- ☐ Shingles
- ☐ Cancer
- ☐ Alcoholism
- ☐ Chemotherapy
- ☐ Anxiety
- ☐ Depression
- ☐ Gout
- ☐ Hepatitis
- ☐ Steroid Therapy
- ☐ Surgery
- ☐ Chronic Fatigue
- ☐ Multiple Sclerosis
- ☐ AIDS
- ☐ HIV
- ☐ Radiation Therapy
- ☐ Tobacco Smoker

Cigarettes/day:_____

Please list all the medications you are taking and what you are taking them for.

Medication	**Condition**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Childhood conditions

Check all the conditions that you have had:

- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Whooping Cough
- ☐ Scarlet Fever
- ☐ Diphtheria
- ☐ Rheumatic Fever
- ☐ Typhoid Fever

Please list all surgeries.

_____

_____

_____

Please list any other ongoing health concerns.

_____

_____

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