westwood
TOTAL HEALTH

Confidential Patient Information

Personal Information

Name:________________________________ Date:________________________________
Address:____
City:______________________________Postal Code:______________________________
Birthdate:_____________ Age:_____ Marital Status: S M D W C/L E Spouse:_____________
#of Children:______ Children Ages:____________ Email:________________________________
Phone #: Home:________________________ Work:____________________
Cell:___________________
Occupation:__________________________ Employer:________________________________
Who may we thank for referring you to our office?:____

Chiropractic History

Have you been to a Chiropractor before:Yes/No Name of Previous Chiropractor:____________________
When:______________ How long did you receive care:______________ Were X-Rays taken:__________

Motor Vehicle Accidents

Have you been in a car accident in the last 2 years:___________ Accident Date:________________
Do you have an open claim with ICBC for this accident:________ Claim number:________________

Goals for Care *(Circle reasons that apply)*

- Symptom Relief
- Correcting the cause of my problem
- 100% optimal health and healing

Major Health Concern

CONDITION 1

Please describe your chief health concern:____

On a scale of 1-10 (10 being worst), how bad is the problem: ____/10

When did the problem start:______________ How:____

Is it: Getting Better? Getting Worse? Staying the Same? On/Off?

How would you describe the problem:____

What activities aggravate the problem (Please Describe):____________________________________

What relieves your symptoms, if any:____

Spinal History

Spinal Subluxations (spinal misalignment) can be cause by traumas such as motor vehicle accidents, falls, heavy lifts, etc. Please list below any falls or accidents that may apply (with approximate dates):

____

____

*Please list any surgeries(with approximate dates)*____

*Are you taking medication? Yes No Please list all medications:*________________________________

____

Health Conditions

Please CIRCLE each of the diseases or conditions that you have now or have had in the past. While some conditions may seem unrelated to the purpose of this appointment, they can affect diagnosis, and care plan.

General
- Dizziness
- Fatigue
- Headache
- Loss of Sleep
- Loss of Weight
- Anxiety/Depression
- Numbness
- Cancer
- Diabetes
- Thyroid Problems
- Epilepsy
- Hyperactivity
- Seizures

Genito-Urinary
- Bed Wetting
- Painful Urination
- Prostate Trouble
- Blood in Urine
- Venereal Disease
- Bladder Infection
- Frequent Urination

Muscle and Joint
- Arthritis
- Hernia
- Low Back Pain
- Neck Pain
- Pain Between Shoulders

Numbness or pain in:
- Shoulders
- Upper Arms
- Hands
- Legs
- Feet
- knees
- Hips

- Poor Posture
- Swollen Joints
- Gout
- Restless Legs
- Polio

Respiratory
- Asthma
- Chronic Cough
- Irregular Breathing
- Wheezing
- Emphysema

Gastrointestinal
- Constipation
- Diarrhea
- Digestive Dysfunction
- Gall Bladder Trouble
- Hemorrhoids
- Liver Trouble
- Ulcers
- IBS
- Crohn's
- Acid Reflux
- Bloating
- Food Sensitivity

Eyes, Ears, Nose, Throat
- Allergies (seasonal)
- Frequent Colds
- Crossed Eyes
- Deafness
- Ear Infections
- Ringing in Ears
- Eye Pain
- Vision Problems
- Nasal Obstruction

Cardio Vascular
- High Blood Pressure
- Low Blood Pressure
- Poor Circulation
- Irregular Heart Beat
- Ankle Swelling
- Anemia
- Arteriosclerosis
- Stroke

Women Only
- Menstrual Cramps
- Excessive Menstruation
- Irregular Cycle
- Hot Flashes

Could you be pregnant?

YES
NO
MAYBE

Date of Last Period: ____________________

CONDITION 2 (if applicable)

Please describe health concern:____

On a scale of 1-10 (10 being worst), how bad is the problem: ____/10

When did the problem start:_______________ How:____

Is it: Getting Better? Getting Worse? Staying the Same? On/Off?

How would you describe the problem:____

What activities aggravate the problem (Please Describe):____

What relieves your symptoms, if any:____

CONDITION 3 (if applicable)

Please describe health concern:____

On a scale of 1-10 (10 being worst), how bad is the problem: ____/10

When did the problem start:_______________ How:____

Is it: Getting Better? Getting Worse? Staying the Same? On/Off?

How would you describe the problem:____

What activities aggravate the problem (Please Describe):____

What relieves your symptoms, if any:____

I certify that the information contained in this form is correct to the best of my knowledge

_______________________________________ ______________________

Patient Signature Date

I give Westwood Total Health permission to send me emails pertaining to my care ie: appointment remainders, billing information, upcoming workshops, and valuable information regarding my care. Should I choose, for any purposes, to unsubscribe from said emails, I will reply with UNSUBSCRIBE in the subject box *(please circle yes or no)*

YES ***NO***