FUNCTION HEALTH
FEEL BETTER

Date:_____

All information is confidential.

Name:_____

Date of Birth: Day_____ Month_____ Year_____ Age_____

May we email? If yes, EMAIL ADDRESS:_____

Address:_____

Town/City: _____**Postal Code**: _____

Primary Phone #:_____ **#2 Phone**:_____

Occupation:_____ **SEX**: M F

Does our office have your consent to leave a message? Yes No

Family Doctor: _____ **Phone**: _____

Emergency Contact:

Name:_____Relationship:_____

Cell:_____ Home:_____ Work:_____

How did you hear about our clinic? (circle)

Website Internet Yellow Pages Health Practitioner Family Doctor

Friend/Family:_____ Other:_____

CONSENT:

In the event that I choose to see more than one practitioner at Function Health, I consent to this information being shared with other Function Health practitioners for the purpose of optimizing my treatment.

_____

Signature

CONFIDENTIAL PATIENT CASE HISTORY FORM

Have you ever had: chiropractic treatment? No Yes, Date: _____

professional massage? No Yes, Date:_____

Have you ever seen a naturopathic doctor? No Yes, Date:_____

Current Complaint(s):_____

_____

Is condition a result of an auto accident? Yes No

Did your condition start due to your work? Yes No

When did it start? _____

Have you visited your medical doctor for this injury? Yes No

Have you had any special tests or imaging done for this condition (please circle):

X-ray MR I Blood work CT Scan Ultrasound other:_____

Have you had treatment for this episode? Yes No

If so, what type of treatment?_____

I would describe the pain as (please circle):

Sharp Dull Throbbing Achy

Numb Tingling Stiffness Burning

Shooting Spasm Other_____

Is the pain: Constant OR Intermittent

What aggravates your condition?

Sitting Standing Bending Lifting

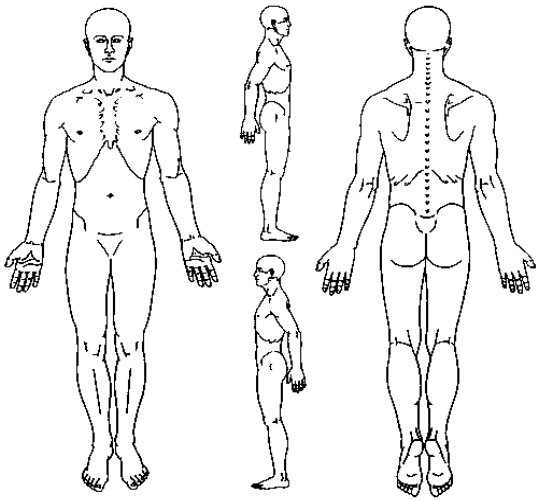
Walking Cold Dampness Laying down

Other:_____

Is the condition getting (please circle):

Better Worse Same Recurring (off & on)

Please circle your area of concern:



Have you experienced any major injuries or surgeries?_____

_____

Please List Any Allergies_____

_____

75 Lincoln Street West Unit 1 · Welland · Ontario L3C 5J3 P (905) 732·0312 F (905) 732·0944

General Systems Review

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

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

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

Neurological
Epilepsy
Convulsions
Fainting
Numbness
Sciatica
Stroke
Seizures
Tingling
Tremors

Lungs and Respiratory
Please list any recent or chronic lung/respiratory conditions:_____

Stomach and Digestion
Appetite changes
Stool changes
Constipation
Crohn's/Colitis
Irritable Bowel Syndrome
Diarrhea
Heart Burn/Ulcers
Nausea
Gall Bladder Problem
Gas/Bloating/Cramping

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

Male Reproductive
Prostate Problems
STD
Trouble with Urination

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: _____

Miscellaneous
Autoimmune disease
Diabetes
Thyroid dysfunction
Psoriasis
Shingles
Cancer/Chemotherapy/Radiation
Anxiety/Depression
Gout
Hepatitis
Steroid Therapy
Chronic Fatigue
Multiple Sclerosis
AIDS/HIV
Tobacco Smoker
Cigarettes/day:_____

Urinary
Bladder or kidney infections
Blood in urine
Burning/pain urinating
Difficulty urinating
Incontinence (leakage)
Kidney Stones
Yeast Infection

Medication/Supplements

_____

_____

_____

_____

_____

_____

_____

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