Dynamic Chiropractic Health & Wellness Centre

Health Status Survey

Patient's Name: ______________________ File #: ____________ Date: ____________

Please circle (O) any conditions or symptoms presently causing you problems.
Please put a checkmark (√) beside those conditions or symptoms, which have been a problem to you in the past.

General Symptoms

Loss of Consciousness
Blackouts
Headaches
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions
Loss of Sleep
Numbness, Pain or Tingling
Nervousness
Loss of Weight

Muscle & Joints

Stiff Neck
Back Ache
Swollen Joints
Painful Tailbone
Foot Trouble
Shoulder Pain
Arm or Forearm Pain
Elbow Pain
Wrist Pain
Arthritis
Weakness or Loss of Strength

Eyes, Ears, Nose & Throat

Blurred Vision
Failing Vision (one or both eyes)
Crossed Eyes
Double Vision
Eye Pain
Deafness
Earache
Ringing, Buzzing, Any Noise in the Ears
Asthma
Frequent Colds
Sinus Infection
Enlarged Glands
Enlarged Thyroids
Slurred or Other Speech Problems
Difficulty Swallowing

Respiratory

Chronic Cough
Spitting up phlegm
Spitting up blood
Chest Pain
Difficulty Breathing

Cardiovascular

Bleeding Disorder
High Blood Pressure
Pain Over Heart
Stroke
Hardening of Arteries
Varicose Veins
Swelling of Ankles
Poor Circulation
Heart or Blood Disease
Angina

Genitourinary

Trouble Urinating
Blood in Urine
Kidney Infection
Bed Wetting
Prostate Trouble

G.U. For Women

Painful Menstruation
Excessive Flow
Hot Flashes
Irregular Cycle
Cramps or Backache
Vaginal Discharge
Swollen Breasts
Lumps in Breast

Have you ever been on birth control pills? Yes ☐ No ☐

Are you currently taking the birth control pill? Yes ☐ No ☐

Number of Pregnancies: ________

Number of Children: ________

Please inform the Clinician if you have ever been tested for HIV or Hepatitis A, Hepatitis B or Hepatitis C

Skin

Rashes, Itching
Bruise easily
Dryness
Boils
Hives (allergy)

Gastrointestinal

Poor Appetite
Indigestion
Excessive Hunger
Belching or Gas
Nausea
Vomiting (blood?)
Pain over stomach
Constipation
Diarrhea
Hemorrhoids
Jaundice
Gall Bladder Trouble
Ulcer
Diabetes

Have you ever had any fractures?
Yes ☐ No ☐

Have you ever been in a car accident?
Yes ☐ No ☐

Have you ever been hospitalized?
Yes ☐ No ☐

If yes, why? ______________

Are you currently a smoker?
Yes ☐ No ☐

Have you ever smoked in the past?
Yes ☐ No ☐

Have you ever been diagnosed with cancer?
Yes ☐ No ☐

Do you take medication on a regular basis?
Yes ☐ No ☐
If so, what? (blood thinner, blood pressure, etc.)

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Please complete the reverse side....