



Patient History

At Pillars of Health, we are interested in your overall health. While a specific health problem may have motivated you to seek help, a broad view of your health history will enable us to determine the cause of the problem. If you have questions, please ask Dr. Prowse-Welch or Dr. Wright during your consultation.

Name: _____ Date: _____

Address: _____

How would you prefer to be contacted?

Home#: _____ Work: _____ Cell: _____ Email: _____

Date of Birth (DD/MM/YY): _____ Occupation: _____

Contact person: Name & #: _____

Previous chiropractor: _____ Family doctor: _____

How did you hear about Pillars of Health?: _____

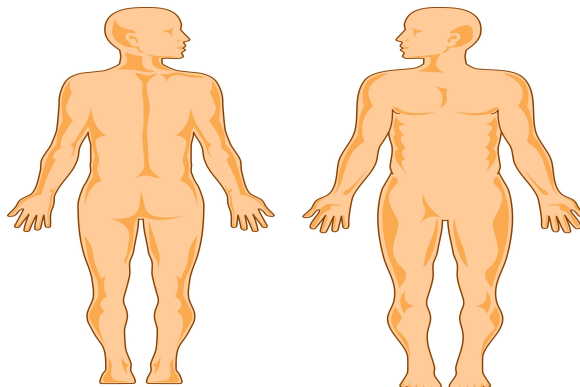
Reason for consulting this office: _____

Are you interested in: relief of symptoms only.

relief of symptoms and correction of underlying problem.

I have no symptoms. I am interested in a chiropractic assessment.

Show areas of pain or unusual feeling.



If you are experiencing pain, it is:

sharp dull comes & goes constant travels improving worsening

If worsening, what makes it worse? _____

Other health care professionals seen for this problem:

Chiropractor Medical Doctor RMT Other: _____

Please review this list. Use a "C" for current symptoms, "P" for past symptoms.

- | | | |
|--|---|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> back pain | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> neck pain/stiffness | <input type="checkbox"/> tingling legs/feet | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> tingling arms/hands | <input type="checkbox"/> numbness legs/feet | <input type="checkbox"/> fainting |
| <input type="checkbox"/> numbness arms/hands | <input type="checkbox"/> problems urinating | <input type="checkbox"/> cold sweats |
| <input type="checkbox"/> cold hands/feet | <input type="checkbox"/> constipation | <input type="checkbox"/> hot flashes |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> diarrhea | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> ringing in ears | <input type="checkbox"/> heartburn | <input type="checkbox"/> depression |
| <input type="checkbox"/> loss of taste | <input type="checkbox"/> ulcers | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> loss of smell | <input type="checkbox"/> menstrual pain | <input type="checkbox"/> mood swings |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> menstrual irregularity | <input type="checkbox"/> high blood pressure |

Current medications: _____

Falls/Accidents/Sports injuries: _____

Surgeries: _____

Childhood Illness/Falls: _____

Family Health History (ie heart disease, cancer)

Mother: _____

Father: _____