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. Wright during your consultation.

Preferred Pronoun (he/him, she/her, they/them, etc.): _____________

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:____

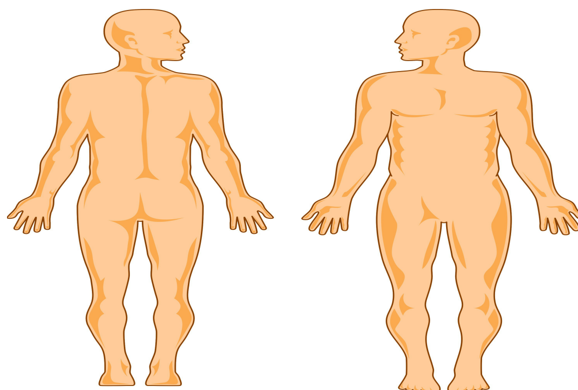
____

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.

_headaches	_back pain	_fatigue
_neck pain/stiffness	_tingling legs/feet	_sleeping problems
_tingling arms/hands	_numbness legs/feet	_fainting
_numbness arms/hands	_problems urinating	_cold sweats
_cold hands/feet	_constipation	_hot flashes
_loss of balance	_diarrhea	_shortness of breath
_ringing in ears	_heartburn	_depression
_loss of taste	_ulcers	_anxiety
_loss of smell	_menstrual pain	_mood swings
_dizziness	_menstrual irregularity	_ high blood pressure

Current medications:____

Falls/Accidents/Sports injuries:____

Surgeries:____

Childhood Illness/Falls:____

Family Health History (ie heart disease, cancer)

Mother:____

Father:____