DR. BARRY YOUNG • 1508 Upper James St, Hamilton, ON L9B 1K3 • DR. JENNIFER KRAGTEN RO

PERSONAL HISTORY

DATE	#

Name____ Address____

City____ Province______________________ Postal Code____________

Home Phone____ Birthdate___________________ Age_________ Sex ❑ M ❑ F

Email____

Business / Employer____________________________________ Type of Work____

Business Phone____ Circle One:

Name & Relationship of Emergency Contact__________________ Married Single Widowed Divorced Separated Other

Phone # of Emergency Contact___________________________ # of Children____

Do you have Extended Health Benefits? ❑ Y ❑ N Insurance Company_____________________________________

Group #______________________ ID#______________________

Who may we thank for referring you to this office____

CURRENT HEALTH CONDITION

Reason for seeking a chiropractic care today?____

Other Doctors seen for this condition: Yes No Who?____

Types of treatment:____________________________________ Results:____

When did this condition begin?_______________________________ **Has this condition occurred before?** ❑ Yes ❑ No

Is condition: ❑ Job Related ❑ Auto related ❑ Home Injury ❑ Fall ❑ Other______________________________

Date of Accident:____ **Time of Accident:**___________________________

What aggravates your condition? ❑ Sitting ❑ Standing ❑ Bending ❑ Lifting ❑ Walking
❑ Lying Down ❑ Cold ❑ Dampness ❑ Other__________________________

What relieves your condition? ❑ Bed rest ❑ Ice ❑ Heat ❑ Massage ❑ Medication
❑ Other____

Is it getting: ❑ Worse ❑ Constant ❑ Comes /Goes ❑ Better

Character of Pain: ❑ Sharp ❑ Dull ❑ Ache ❑ Pins & Needles ❑ Burning
❑ Constant ❑ Comes & Goes ❑ Radiating ❑ Numb

Please circle the severity of the pain at it's worst Least -- 1 2 3 4 5 6 7 8 9 10 -- Worst

Does this cause you to be...
- ❑ Moody
- ❑ Irritable
- ❑ Interrupted Sleep
- ❑ Restricted Daily Activity

Does this affect your work...
- ❑ Decision Making
- ❑ Poor Attitude
- ❑ Decreased Productivity
- ❑ Exhausted at End of Day
- ❑ Unable to Work Long Hours

Does this affect your life...
- ❑ Lose patience with spouse or child
- ❑ Restricted household duties
- ❑ Hinder ability to exercise
- ❑ Hinder ability to do hobbies

If you don't get this problem corrected, do you think it will get worse over the next 5 years? ❑ Yes ❑ No

Drugs you now take: ❑ Nerve Pills ❑ Pain Killers / Muscle Relaxers ❑ Blood Pressure ❑ Cholesterol
❑ Insulin ❑ Birth Control ❑ Anti-depressants ❑ Other____________________

Are you being treated for any other medical conditions?____

Have you had any X-rays taken in the last 6 months? ❑ Yes ❑ No If yes, where?____________________________

PAST HEALTH HISTORY

Please check or describe:

Major Surgery / Operations: ❑ Appendectomy ❑ Tonsillectomy ❑ Gall Bladder ❑ Hernia ❑ Back Surgery
❑ Broken Bones ❑ Hysterectomy ❑ Other:____

Previous: Childhood Traumas ❑ ______________________________ Sports Injuries ❑ ______________________________
Motor Vehicle Accident ❑ ____________________________ Work Injuries ❑ ______________________________

Hospitalizations (other than above):____

Previous Chiropractic Care: ❑ None ❑ Yes, Doctors name and approx. date of last visit:_________________________

FAMILY HEALTH HISTORY

Does any member of your family suffer from the same condition? ❑ No ❑ Yes Whom?___________________________

Have your children ever had a spinal checkup? ❑ No ❑ Yes

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can effect your overall course of chiropractic care.

Check any of the following Diseases you have had:

- ❑ Pneumonia
- ❑ Mumps
- ❑ Influenza
- ❑ Rheumatic Fever
- ❑ Small Pox
- ❑ Pleurisy
- ❑ Polio
- ❑ Chicken Pox
- ❑ Arthritis
- ❑ Tuberculosis
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Whooping Cough
- ❑ Cancer
- ❑ Mental Disorder
- ❑ Anemia
- ❑ Heart Disease
- ❑ Lumbago
- ❑ Measles
- ❑ Thyroid
- ❑ Eczema

Check any of the following you have had in the past six months:

Musculo-Skeletal

- ❑ Low Back Pain
- ❑ Gas/Bloating After Meals
- ❑ Pain Between Shoulders
- ❑ Heartburn
- ❑ Neck Pain
- ❑ Black/Bloodly Stool
- ❑ Arm Pain
- ❑ Colitis
- ❑ Joint Pain/Stiffness
- ❑ Walking Problems
- ❑ Difficult Chewing/Clicking Jaw
- ❑ General Stiffness

Nervous System

- ❑ Nervous
- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion/Depression
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold/Tingling Extremities
- ❑ Stress

C-V-R

- ❑ Chest Pain
- ❑ Short Breath
- ❑ Blood Pressure Problems
- ❑ Irregular Heartbeat
- ❑ Heart Problems
- ❑ Lung Problems / Congestion
- ❑ Varicose Veins
- ❑ Ankle Swelling
- ❑ Stroke

General

- ❑ Fatigue
- ❑ Allergies
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches

EENT

- ❑ Vision Problems
- ❑ Dental Problems
- ❑ Sore Throat
- ❑ Ear Aches
- ❑ Hearing Difficulty
- ❑ Stuffed Nose

Gastro-Intestinal

- ❑ Poor / Excessive Appetite
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver Problems
- ❑ Gall Bladder Problems
- ❑ Weight Trouble
- ❑ Abdominal Cramps

Male/Female

- ❑ Menstrual Irregularity
- ❑ Menstrual Cramping
- ❑ Vaginal Pain / Infections
- ❑ Breast Pain / Lumps
- ❑ Prostate / Sexual Dysfunction

Genito-Urinary

- ❑ Bladder Trouble
- ❑ Painful / Excessive Urination
- ❑ Discoloured Urine

Females Only

When was your last period?____________

Are you pregnant?

❑ Yes ❑ No ❑ Not Sure

Intake

- ❑ Coffess
- ❑ Tea
- ❑ Alcohol
- ❑ Cigarettes
- ❑ White Sugar

Personal Satisfaction with Diet

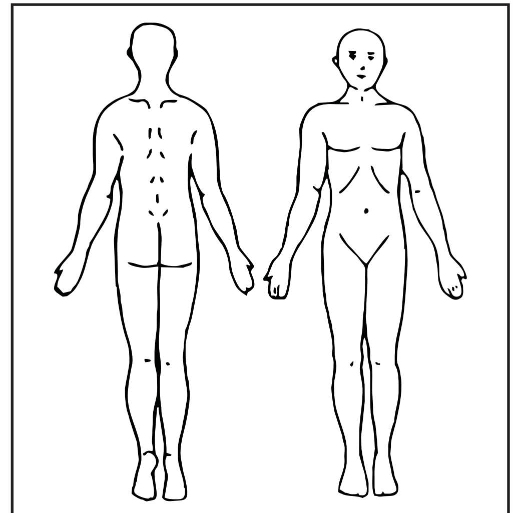
- ❑ Highly Satisfies
- ❑ Dissatisfied
- ❑ Highly Dissatisfied

Do you have a regular exercise program?

- ❑ Yes
- ❑ No

Lifestyle Stress Levels

- ❑ High
- ❑ Moderate
- ❑ Very Little



Please outline on the diagram the area of your discomfort and any radiation of pain.