TIMMINS CHIROPRACTIC clinic
36 Pine Street South • Timmins, ON • P4N 2J8 • (705) 268-9099 • timminschiro@gmail.com

# Confidential Health Status Survey

Patient Name: _____ File No.: _____ Date: _____
(dd/mm/yy)

Patient information contained within this form is considered **strictly confidential.**
Your responses are important to help us better understand the health issues you face and ensure the delivery of the best treatment possible.

Please check (✓) any conditions or symptoms causing you problems.
Please circle (O) those conditions or symptoms, which have been a problem to you in the past.

**General Symptoms:**
☐ Allergies
☐ Depression
☐ Dizziness
☐ Fainting
☐ Fatigue
☐ Fever
☐ Headaches
☐ Loss of sleep
☐ Mental illness
☐ Numbness or tingling
☐ Nervousness
☐ Weight loss/gain

**Muscles & Joints:**
☐ Stiff neck
☐ Low back pain
☐ Mid back pain
☐ Painful tailbone
☐ Joint pain
☐ Swollen joints
☐ Foot trouble
☐ Shoulder pain
☐ Arm/Forearm pain
☐ Elbow pain
☐ Wrist/Hand pain
☐ Arthritis
☐ Bursitis
☐ Weakness or loss of strength

**E.E.N.T.:**
☐ Blurred vision
☐ Failing vision
☐ Crossed eyes
☐ Double vision
☐ Eye pain
☐ Deafness
☐ Earache
☐ Ringing/buzzing in ears
☐ Asthma
☐ Frequent colds
☐ Sinus infection
☐ Enlarged glands
☐ Enlarged thyroid
☐ Speech problems
☐ Difficulty swallowing

**Respiratory:**
☐ Chronic cough
☐ Spitting up phlegm
☐Spitting up blood
☐ Chest pain
☐ Difficultly breathing

**Cardiovascular:**
☐ Bleeding disorder
☐ High blood pressure
☐ Pain over heart
☐ Stroke
☐ Hardening of arteries
☐ Varicose veins
☐ Swelling of veins
☐ Swelling of ankles
☐ Poor circulation
☐ Heart or blood disease
☐ Angina

**Genitourinary:**
☐ Trouble urinating
☐ Blood in urine
☐ Kidney infection
☐ Bed wetting
☐ Prostate trouble

**Skin:**
☐ Rashes/itching
☐ Bruise easily
☐ Dryness
☐ Boils
☐ Hives (allergy)

**Gastrointestinal:**
☐ Poor appetite
☐ Indigestion
☐Excessive hunger
☐ Belching or gas
☐ Nausea
☐ Vomiting
☐ Stomach pain
☐ Constipation
☐ Diarrhea
☐ Hemorrhoids
☐ Jaundice
☐ Gallbladder trouble
☐ Parasite
☐ Ulcer
☐ Diabetes

**Women Only:**
☐ Painful menstruation
☐ Hot flashes
☐ Irregular cycle
☐ Cramps/backache
☐ Vaginal discharge
☐Swollen breasts
☐ Lumps in breasts

Are you pregnant? ☐ Yes ☐ No
Have you ever been on birth control pills? ☐ Yes ☐ No
Are you currently taking birth control pills? ☐ Yes ☐ No
# of pregnancies _____
# of children _____

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 smoked in the past? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No
How many drinks/week? _____

Have you ever been diagnosed with cancer? ☐ Yes ☐ No
Have you been diagnosed with HIV/AIDS? ☐ Yes ☐ No
Have you been diagnosed with Hepatitis A, B or C? ☐ Yes ☐ No
Please list all medications (blood thinner, blood pressure):
_____
_____

**Please complete the reverse side.**

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# Confidential Health Status Survey

(Side 2)

Give a brief description of the problem you are currently experiencing: _____

_____

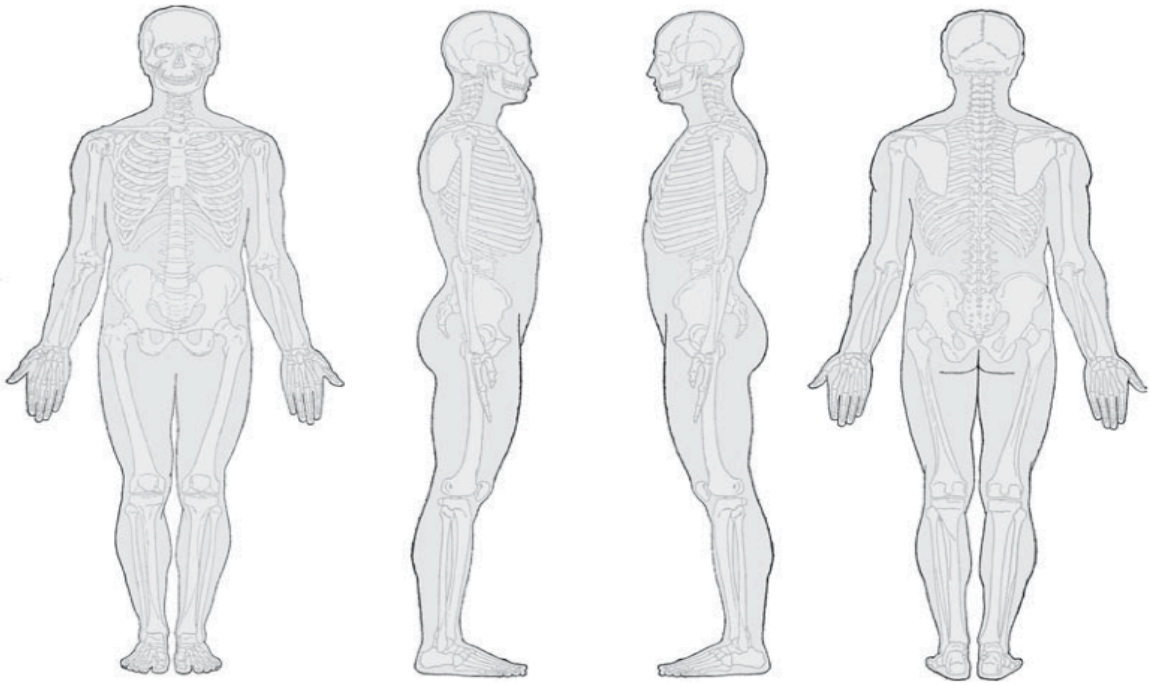
_____

_____

How long have you had this condition? _____ Is it getting worse? ☐ Yes ☐ No

In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain(s) or sensations(s) you are experiencing. Please include *all* areas. Use the symbols provided below.

| | | |
|---|---|---|
| Numbness ==== | Pins & Needles •••• | Burning xxxx |
| Stabbing & Sharp ///// | Dull & Aching ++++ | Stiff & Tight 2222 |



Front Right side Left side Back

_____