ACTIVE HEALTHCARE CENTRE
25 Stonebridge Blvd. Unit 2
Wasaga Beach, ON L9Z 0C1
Tel: 705-422-0224 Fax: 705-422-7109

Date: _____

Personal History

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Phone Number (Home): _____ (Work): _____ (Cell) _____

May we leave messages? Y / N

Email (We will send appointment information to this e-mail) _____

Patient's Birth Date (DD / MM / YYYY): _____ Age: _____ Gender: Male / Female

Occupation: _____ What activity do you do most (sit/stand etc): _____

Height: _____ Weight: _____

Emergency Contact Name: _____ and Phone: _____

Who may we thank for referring you to this office? Name: _____ Or check one of the following;

__ Yellow pages __ Internet __ Newspaper ___ Family Doctor Other: _____

Current Health Condition

Please describe your present complaint:

When did it occur? _____ How did it occur? _____

Have you received any treatment for this condition, and if so what kind of treatment? _____

_____

Family Doctor: _____ and Phone: _____

Does your MD know about this condition? Y / N If yes, type of treatment: _____

Has any treatment helped? _____

Has this condition occurred before? Y / N When? _____

Is this condition:

__ Work Related (WSIB) __ Auto Related (MVA) __ Home injury __ Fall __ Other: _____

What aggravates your condition?

__ Sitting __ Lying Down __ Lifting __ Walking

__ Cold __ Heat __ Bending __ Dampness __ Other: _____

What relieves your condition?

__ Bed Rest __ Medication __ Heat __ Ice __ Massage __ Other: _____

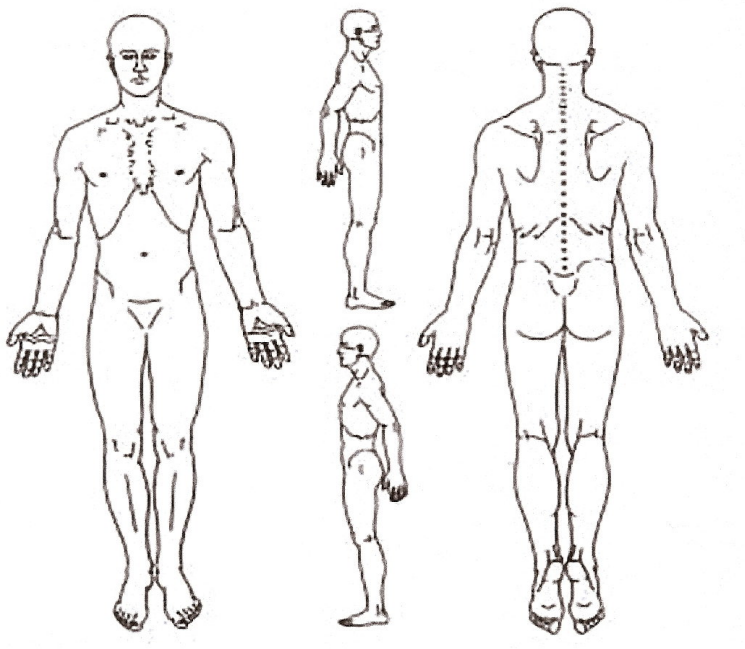
Is the Pain Getting: __ Worse __ Better __ Constant __ Comes and Goes

Character of Pain: __ Sharp __ Dull __ Ache __ Pins and Needles

__ Burning __ Numb __ Inconsistent __ Constant

On the diagram to the right please use listed symbols to outline the area of your discomfort and any radiating pain:

Ache: XXXX
Stiffness: ####
Stabbing: 2222
Numbness: ++++
Pins & Needles: 0000



Please indicate the **severity** of your symptoms (Circle # which indicates your pain intensity):

Least 1 2 3 4 5 6 7 8 9 10 Most

Have you had x-rays taken for this complaint? _____

Have you been to a chiropractor before? Y /N If Yes, Name and date last treatment? _____

Do you Currently Smoke? Y / N _____

How often do you exercise? _____ What kind of activity is it? _____

Prior surgeries? _____

Prior Hospitalizations? _____

Have you Broken any bones? _____

Do you currently take any prescription or over the counter medications or vitamins/nutritional supplements? Y / N
Specify:

_____

_____

Females only:

Date of Last Menstrual Period: _____

Are You Currently Pregnant? _____

Client Health History:
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 affect your overall course of natural healthcare.

Please **check (√)** anything which is causing you problems right now
Please **circle (O)** anything which has been a problem in the past

__ Cancer: _____
__ Thyroid
__ Eczema
__ Diabetes: Type I / Type II
__ Depression
__ Mental Disorder
__ Pneumonia
__ Whooping Cough
__ Mumps
__ Measles
__ Influenza
__ Rheumatic Fever
__ Pleurisy
__ Polio
__ Tuberculosis
__ Epilepsy
__ Seizures
__ HIV
__ Allergies: _____
__ Other: _____

MUSCULO-SKELETAL
__ Arthritis
__ Osteoporosis
__ Neck Pain
__ Shoulder Pain
__ Upper Back
__ Mid Back
__ Low Back
__ Arm Pain
__ Legs
__ Knees
__ Feet
__ Walking problems
__ Sore/Clicking Jaw

RESPIRATORY
__ Lung Problems
__ Emphysema
__ Bronchitis
__ Cough / Congestion

NERVOUS SYSTEM
__ Numbness
__ Paralysis
__ Dizziness
__ Convulsions
__ Cold/Tingly Extremities
__ Stress

CARDIOVASCULAR
__ Stroke
__ Blood Pressure
__ Chest pain
__ Shortness of breath
__ Heart attack
__ Pacemaker
__ Ankle Swelling
__ Fainting

GI DISORDERS
__ Bladder trouble
__ Painful Urination
__ Frequent Urination
__ Discoloured Urine
__ Black / Bloody Stool
__ Heartburn
__ Colitis/Chrons Disease

EENT
__ Headaches
__ Vision Problems
__ Dental Problems
__ Sore Throat
__ Hearing Difficulty

LIFESTYLE STRESS
__ High
__ Moderate
__ Low

General:
__ Fatigue __ Loss of Sleep __ Fever __ Weight Change __ Bowel / Bladder

Family History:
Have your grandparents, parents or siblings ever been diagnosed with any of the following?

__ High blood pressure
__ Heart Disease
__ Stroke
__ Diabetes
__ Rheumatoid Arthritis
__ Osteoarthritis
__ Neurological Problems
__ Cancer
__ Thyroid/ Hormone problems
__ Kidney Disease
__ Breathing or lung problems
__ Other Specify:

Are there any other conditions that run in your family that you feel are important for us to know about?

_____

Other Information:
What would you like to achieve by coming to our clinic?

_____
(Our primary goal is always to work toward resolution of your condition as quickly as possible.)

Do you have concerns about the therapy that you would like us to address before we begin treatment?

_____

_____
(We believe that good client communication is essential and we always want to know your perspectives –positive or negative)

I hereby authorize Dr. Elizabeth Koehle and/or Dr. James Koehle with my prior knowledge, to release to or obtain any health information from my other healthcare providers as may be required for the management of my case.

I have read and understand the Active Healthcare Centre fee schedule and cancellation policy. I am aware that if insurance claims are being submitted on my behalf that I am responsible for any outstanding balance not covered by my insurance policy.

Patient's Signature: _____
Patient or Legal Guardian