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: _____ Preferred Name: _____

Preferred Salutation/ Pronoun (optional)_____Address: _____

City: _____ Province: _____ Postal Code: _____

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

May we leave messages? Y / N Email: _____

Patient's Birth Date (DD / MM / YYYY): _____ Age: _____ Height: _____ Weight: _____

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

Please describe your current relationship status: □ Single □ Married □ Divorced □ Prefer Not To Say

Emergency Contact Name: _____ and Phone: _____

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

__ Yellow pages __ Newspaper ___ Webpage __ Social Media, 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

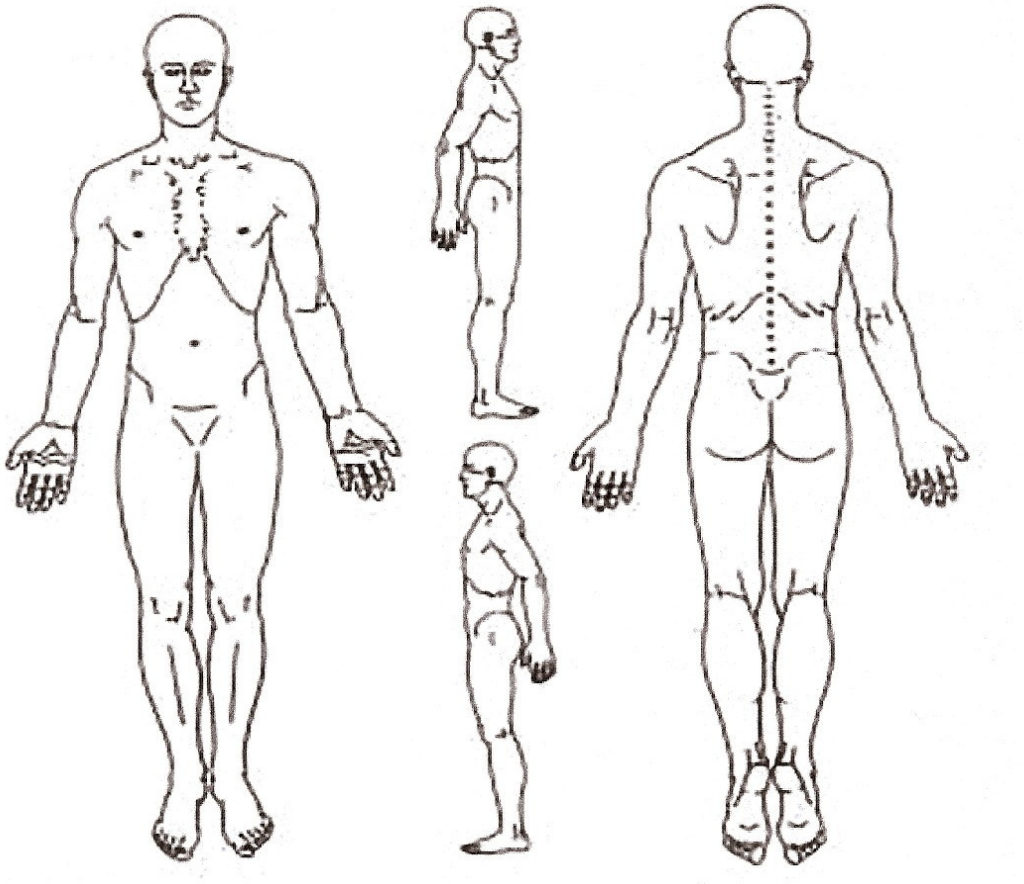
__ Burning __ Numb __ Inconsistent __ Constant

**Symptom Diagram**

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

**Symbols:**

| | | | |
|---|---|---|---|
| **Numbness** | **======** | **Pins and Needles** | **oooooo** |
| **Burning** | **xxxxxx** | **Stabbing and Sharp** | **~~~~~~** |
| **Dull and Aching** | **??????** | **Stiff and Tight** | **222222** |



**Left Side** **Right Side**

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

If you don't get this problem corrected, do you think it will get worse over the next 5 years? Y / N

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? _____

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

Prior surgeries? _____

**Health Status Survey:**
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.
Present Symptoms: Please √ the box for any conditions or symptoms currently causing you problems.
Past Symptoms: Please **X** the box for any conditions or symptoms that you have had in the past.

**Gastrointestinal**
□Poor appetite
□Indigestion
□Excess hunger
□Belching or gas
□Vomiting
□Pain over stomach
□Constipation
□Hemorrhoids(piles)
□Jaundice
□Gallbladder trouble
□Intestinal worms
□Ulcer
□Diabetes
□Diarrhea

**Neurologic**
□Dizziness
□Fainting
□Problems speaking
□problem swallowing
□Blurred vision
□Double vision
□Clumsiness
□Numbness or tingling

**Cardiovascular**
□Bleeding disorder
□High blood pressure
□Chest pain
□Stroke
□Hardening of arteries
□Varicose veins
□Swelling of ankles
□Poor circulation
□Heart/blood disease
□Angina

**General Symptoms Muscles & Joints**
□Loss of Consciousness
□Blackouts
□Headache
□Fever
□Excess Sweating
□Night Sweats
□Night Pain
□Loss of weight
□Convulsions
□Generalized pain

**Genitourinary**
□Trouble urinating
□Blood in urine
□Kidney infection
□bedwetting
□prostate trouble

**Menstrual Related**
□Painful menstruation
□Excessive flow
□Hot flashes
□Irregular/ absent cycle
□Cramping/backache
□Abnormal vaginal discharge
□Swollen breasts
□Lump in breasts

**Muscles & Joints**
□Sore/stiff neck
□Low back pain
□Mid back ache
□Painful Tailbone
□Shoulder pain
□Arm/forearm pain
□Wrist/hand pain
□Hip pain
□Knee pain
□Ankle/foot trouble
□Arthritis
□Loss of strength

**Eyes/Ears/Nose/Throat**
□Failing vision
□Eye pain
□Failing hearing
□Earache
□Ring/buzzin ears
□Frequent colds
□Sinus infection
□Enlarged thyroid
□Enlarged glands
□Nervousness
□Convulsions

**Respiratory**
□Asthma
□Chronic cough
□Spitting up phlegm
□Spitting up blood
□ Difficulty breathing

**Skin**
□Rashes/itching
□Bruise easy
□Dryness
□Boils
□Hives(allergies)

**Have you had a bone density scan?**
□ Yes □ No
**Currently on birth control?**
□ Yes □ No
**Previously on birth control?**
□ Yes □ No
**Number of Pregnancies:**_____
**Number of children:**_____

**Have you ever had any fractures?**
□ Yes □ No
If yes – where?_____
**Have you ever been in a car accident?**
□ Yes □ No
If yes – when?_____
**Have you ever been hospitalized?**
□ Yes □ No
If yes – why/when?_____
_____
**Are you currently a smoker?**
□ Yes □ No
If yes- how much? _____
**Did you previously smoke?**
□ Yes □ No
If yes-how much?_____

**Have you ever been diagnosed with:**
Cancer □ Yes □ No
HIV/AIDS □ Yes □No
Hep A/B/C □ Yes □ No
**Have you ever had any mental issues?**
□Depression
□Anxiety
□Nervousness
□ Trauma related conditions
□Substance related conditions
□Personality Disorder
□ Bipolar disorder
Other (please list0:
_____
_____
_____
**Medications (please list):**
_____
_____
_____

**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**