The Britannia Clinic ™
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Offering Programs of
Hope and Healing
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PERSONAL HISTORY FORM

CASE #: **Date:**

Name: Preferred Name:

Address:

Postal Code:

Home: [ ] **Work**: [ ] **Cell:** [ ]

Email:

Date of Birth: (day/month/year) **Alberta Health Care #:**

Age: **Sex:** **F** **M** **Weight:** **Height:**

Marital Status: M S W D No. of children (if applicable): Age(s):

Occupation: Employer:

Is this a Workers Compensation Board claim? : **Yes [ ]** **No [ ]**

Is this a Motor Vehicle Accident claim? : **Yes [ ]** **No [ ]**

Emergency Contact Name: **Phone #:** **Relationship:**

Who recommended this clinic to you?

What is the primary reason for seeking care in this clinic?

What do you hope to achieve by receiving care in this clinic?

Date this condition was first noticed:

What event created this condition?

What care have you received for this condition, and was it helpful?

Please check if you now have or have ever experienced any of the conditions listed below:

HEAD & NECK	Past	Present
Dizziness	( )	( )
Headaches	( )	( )
Stiff/Sore Neck	( )	( )
Swollen Glands	( )	( )
Loss of Smell	( )	( )
Sinus Problem	( )	( )
Nosebleeds	( )	( )

EYES	Past	Present
Blurred Vision	( )	( )
Excessive Tearing	( )	( )
Blind Spots	( )	( )
Corrective Lenses	( )	( )
Double Vision	( )	( )
Dryness	( )	( )
Itching	( )	( )
Pain	( )	( )
Sensitivity	( )	( )

EARS	Past	Present
Discharges	( )	( )
Hearing Loss	( )	( )
Infections	( )	( )
Itching	( )	( )
Pain	( )	( )
Ringing	( )	( )

NEUROLOGICAL	Past	Present
Convulsions	( )	( )
Incoordination	( )	( )
Loss of Balance	( )	( )
Memory Lapse	( )	( )
Neuritis	( )	( )
Neuralgia	( )	( )
Nervous Breakdown	( )	( )
Paralysis	( )	( )
Sense Impairment	( )	( )
Sciatica	( )	( )
Tremors	( )	( )
Twitching	( )	( )
Tingling Sensations	( )	( )

GENERAL	Past	Present
Anemia	( )	( )
Cancer	( )	( )
Diabetes	( )	( )
Epilepsy	( )	( )
Hemophilia	( )	( )
Hypoglycemia	( )	( )
Multiple Sclerosis	( )	( )
Thyroid	( )	( )
Stroke	( )	( )
Tumors	( )	( )

CARDIO RESPIRATORY	Past	Present
Asthma	( )	( )
Chest Pain	( )	( )
Chronic Cough	( )	( )
Difficulty Breathing	( )	( )
Pain in Left Arm	( )	( )
Spit up Blood	( )	( )
Spit up Phlegm	( )	( )
Tightness in Chest	( )	( )
Wheezing	( )	( )
Angina	( )	( )
Bronchitis	( )	( )
Harding of the Arteries	( )	( )
High Blood Pressure	( )	( )
Low Blood Pressure	( )	( )
Poor Circulation	( )	( )
Rapid Heart Beat	( )	( )
Slow Heart Beat	( )	( )
Swelling of Ankles	( )	( )

GENITOURINARY	Past	Present
Blood in Urine	( )	( )
Difficult Urination	( )	( )
Frequency	( )	( )
Infections	( )	( )
Loss of Bladder Control	( )	( )
Prostate Problems	( )	( )
Kidney Disease	( )	( )
Venereal Disease	( )	( )

GASTROINTESTINAL	Past	Present
Abdominal Pain	( )	( )
Diarrhea	( )	( )
Gallbladder Disease	( )	( )
Ulcers	( )	( )
Hernias	( )	( )

OB/GYN

Date of Last Period

Number of Pregnancies:	( )	
Number of Births:	( )	
Hysterectomy:	Yes [ ]	No [ ]
Are you pregnant now?:	Yes [ ]	No [ ]

Do you have a family history of any of the following:

Cancer	Yes [ ]	No [ ]
Diabetes	Yes [ ]	No [ ]
Hypertension	Yes [ ]	No [ ]

REVIEW OF CONDITIONS

1.) HEADACHES:

Do you experience headaches? Yes [ ] No [ ] **If Yes, how often?:**

Please not the usual location: Front Back Left Side Right Side

How long do the headaches generally last? Hours Days Vary

What is the average intensity of the headaches on a scale of 0 (mild) to 10 (severe):

When did you first start having headaches?

Is there anything that seems to trigger the headaches?

Is there anything that seems to relieve the headaches?

2.) CERVICAL (NECK):

Do you experience any neck discomfort? Yes [ ] No [ ] If Yes:

Please describe as: Pain Tightness Stiffness Ache Other

Is this problem constant? [ ] or periodic [ ]

When did this problem begin?

Was there a cause for the symptoms to begin?

Do you experience any of the following? radiating pain [ ] numbness [ ]

or tingling [ ] in your arms [ ] or hands [ ]

3.) SHOULDERS:

Do you experience any shoulder discomfort? Yes [ ] No [ ] If Yes:

What area is involved? Left [ ] Right [ ] Both [ ]

Please describe pain as: Pain Tightness Stiffness Ache Other

Is this problem: constant [ ] or periodic [ ]

When did this problem begin?

Was there a cause for the symptoms to begin?

4.) THORACIC (UPPER BACK):

Do you experience any upper back discomfort? Yes [ ] No [ ] If Yes:

Please describe as: Pain Tightness Stiffness Ache Other

Is this problem: constant [ ] or periodic [ ]

When did this problem begin?

Was there a cause for the symptoms to begin?

5.) CHEST & RIBS:

Do you experience pain in your chest or ribs? Yes [ ] No [ ] If Yes:
What area is involved? Left Ribs [ ] Right Ribs [ ] Chest [ ]
Please describe pain as: Pain Tightness Stiffness Ache Other
Is this problem: constant [ ] or periodic [ ]
When did this problem begin?
Was there a cause for the symptoms to begin?

6.) LUMBAR (LOWER BACK):

Do you experience any lower back discomfort? Yes [ ] No [ ] If Yes:
Please describe pain as: Pain Tightness Stiffness Ache Other
Is this problem: constant [ ] or periodic [ ]
When did this problem begin?
Was there a cause for the symptoms to begin?

Do you experience any of the following? radiating pain [ ] numbness [ ]
or tingling [ ] in your legs [ ] or feet [ ]

7.) HIPS & LOWER EXTREMITIES:

Do you experience any hip discomfort? Yes [ ] No [ ] If Yes:
What area is involved? Left [ ] Right [ ] Both [ ]
Please describe pain as: Pain Tightness Stiffness Ache Other
Is this problem: constant [ ] or periodic [ ]
When did this problem begin?
Was there a cause for the symptoms to begin?

Do you experience any lower extremity (knees, ankles, feet) discomfort? Yes [ ] No [ ] If Yes:
What area(s) are involved?
Please describe pain as: Pain Tightness Stiffness Ache Other
Is this problem: constant [ ] or periodic [ ]
When did this problem begin?
Was there a cause for the symptoms to begin?

Do you have any other structural or muscular complaints? If yes, please describe:

NOTES:

PREVIOUS HEALTH HISTORY

1.) MOTOR VEHICLE ACCIDENTS:

Please list all accidents (including pedestrian). Include the date, type of accident (i.e. rear-end/roll over / front-end/ broad-sided), whether high/medium/low impact, if seat belt was worn and a brief description of symptoms and treatment.

Date	Type	Impact	Seat Belt Y/N	Immediate Symptoms & Treatment

2.) INJURIES & TRAUMAS:

Please list all injuries, traumas, and stresses (either physical or emotional) that you have experienced. Include the year of the event, area affected, any treatment and result of treatment (i.e. good, worse, no change, temporary, improvement).

Date	Area	Treatment	Result of Treatment

3.) SURGERY:

Please list all surgery, especially those that required a general anesthetic. Include the date, procedure, and the outcome to the procedure.

Date	Procedure	Result of Procedure

NOTES:

YOUR MEDICAL DOCTOR:

Name, address and phone number:

Date of your last complete physical:

Date and reason for your consult with a doctor:

Please list any current prescriptions or other medications:

PRIOR CHIROPRACTIC CARE: Please list previous chiropractic treatment. Include name, area treated, date you started care, date of your last visit, results of the treatment (good, worse, temporary improvement, no improvement) date and area of any x-rays.

Name	Area treated	Start Date	Last visit	Results	Date and Area X-ray

OTHER HEALTH CARE PROFESSIONALS: Medical specialists/ acupuncturists/ naturopaths/ massage therapy/ physiotherapy/etc. Include name, type of professional, reason for care, date of last visit, duration and results of any treatment.

Name	Profession	Reason for care	Last visit	Duration and Result of Treatment

DIAGNOSTIC PROCEDURE: Please list any x-rays, ultrasounds, Cat Scans, MRIs, or other procedures. Include the date, type or procedure, area examined and results. If possible, please provide a copy of the report.

Date	Procedure	Area Examined	Results

NOTES:

HEALTH HISTORY

ALLERGIES: Please list the allergy, reaction and treatment

Allergy	Reaction	Treatment

PRESCRIPTION MEDICATION(S): Please list the current prescribed medication:

Name	Dosage	Frequency	How Long	Reason for Taking

DO YOU USE:

Aspirin:	frequently [ ]	seldom [ ]	never[ ]
Sleeping pills:	frequently [ ]	seldom [ ]	never[ ]
Anti-inflammatories:	frequently [ ]	seldom [ ]	never[ ]

OVER THE COUNTER MEDICATION(S): Please list current medication:

Name	Dosage	Frequency	How Long	Reason for Taking

VITAMINS, HERB & FOOD SUPPLEMENTS: Please include the Brand Name and if capsule or tablet:

Brand Name	Dosage	Frequency	How Long	Reason for Taking

LIFESTYLE:

Physical Activity:

What statement best describes your level of activity?

sedentary [ ] light exercise [ ] physically active [ ] strenuous exercise [ ]

Please list any physical activities and frequency:

Activity	Daily	Times per Week	Seasonal	Intermittent

NOTES:

ALCOHOL USE:

Record your Current Alcohol Consumption:

TYPE:

[ ] 1 oz. spirit [ ] 4 oz. wine [ ] 8 oz. wine [ ] 1 bottle beer

FREQUENCY:

[ ] none [ ] less than 1-2 per month [ ] Less than 7 per week [ ] More than 7 per week

SMOKING: Do you smoke?

[ ] Yes, I currently smoke. If yes, how many cigarettes (including cigars) do you smoke daily? [ ]

[ ] No, I have never smoked.

[ ] No, but I did smoke in the past.

[ ] No, but I have lived with smokers.

CAFFEINE: Do you drink coffee or any beverages with caffeine? Yes [ ] No [ ]

If yes, how many cups/glasses daily?

WATER:

How much water do you drink daily? 1-2 glasses [ ] 2-4 glasses [ ] 5-6 glasses [ ] 7 glasses plus [ ]

STRESS & SUPPORT:

Do you consider your life stressful? Yes [ ] No [ ]

On a scale from 1-10 (10 being extremely stressful and 1 being very peaceful) please rate your life stresses:[ ]

What do you do to manage or cope with these stresses?

Have you had any major changes in your life in the past year? (i.e. moving your house of office, death of a family member or friend, change or job or career, change of school, etc.)

Do you feel rested when you awaken in the morning? Yes [ ] No [ ]

How many hours of sleep do you usually average per night? [ ]

Do you have any other quiet time during your day to rest? Yes [ ] No [ ]

We believe that patients must take personal responsibility to maintain their health. We are here to assist in that process and to provide treatment, education and support. How long do you think it will take to regain optimal health?

Your signature will verify that the information given is accurate:

Print Name: Date:

Signature: Case Number: