



Achieve Health

Chiropractic / Naturopathic / Massage Therapy/ Acupuncture
Dr. Deirdre O'Neill

Today's Date _____

Patient's Name _____
(last name) (first name) (middle initial)

Age: _____ Gender: Female Male Date of Birth: ____/____/____

Address: _____
(street address) (city) (province) (postal code)

Telephone: Home _____ Work _____ Cell _____

May we leave messages on your phone line? ____ Preference (circle all applicable): Home/ Work/ Cell

Email: _____

How did you hear about this clinic? _____

Emergency Contact: _____
(name) (relationship) (telephone)

Insurance Company Name & Group Number: _____

Name of Insured: _____

Primary physician? _____ Last physical exam? _____
(name) (telephone) (month) (year)

Please list and describe your medical problems and health concerns in order of importance:

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

Hospitalizations /Surgery /Accidents

What hospitalizations or surgeries have you had?

_____ year: _____

_____ year: _____

_____ year: _____

List any accidents:

_____ year: _____

_____ year: _____

_____ year: _____

Name: _____ DOB: _____

EXERCISE

Is weight a current concern: Y N Lowest adult weight _____ What age _____

What type of exercise? Walk/Hike _____ Jog/Run _____ Bike _____ Golf _____

Yoga _____ Tennis _____

Other _____

Duration of exercise and how often? _____

Hobbies and/or other activities:

WOMAN'S HEALTH HISTORY

Current Cycle/Hormone concerns:

GYN MEDICAL HISTORY

Please mark: Y=Yes, current or recent problem; N=No, never a problem; P= Past problem

STD: Y N P Chlamydia _____ Gonorrhea _____ Hepatitis _____ Herpes _____ HIV _____
Syphilis _____

Prone to:

Breast cysts:	Y N P	Vaginitis:	Y N P	Endometriosis:	Y N P
Ovarian cysts:	Y N P	Fibroids:	Y N P	Bladder infections:	Y N P
Constipation:	Y N P	Diarrhea:	Y N P		

MENSTRUAL CYCLES

Age period first started: _____

Did it start regular or skip months: _____

Current period: Regular ___ Irregular ___ Cramps ___ Ovulation symptoms ___

PMS symptoms if any:

Birth control pill: Y N P How long: _____ Depo shot: Y N P How long: _____

Any symptoms: If yes, explain:

Name: _____ DOB: _____

PREGNANCY

Infertility Y N P: Miscarriage/Abortions: Y N P Live birth: Y N P

Number of pregnancies: _____

Did you nurse? _____

Normal deliveries: _____

USE OF HORMONE REPLACEMENT THERAPY

List creams, lozenges, patch, pellets, pills, shots, etc:

Review of Systems

General

- Insomnia
- Fatigue
- Weight Loss
- Weight Gain
- Head
- Headache
- Dizziness
- Head Trauma
- Fainting
- Blacking out

Eyes

- Itching/redness
- Change in vision
- Cataracts
- Light sensitivity
- Flashes in vision
- Spots in vision
- Glaucoma

Ears

- Ringing/ tinnitus
- Impaired Hearing
- Earache
- Dizziness
- Discharge

Mouth and Throat

- Bleeding gums
- Cold sores
- Sore throat
- Jaw/TMJ problems
- Hoarseness
- Swollen glands
- Goiter

Nose

- Hayfever
- Loss of smell
- Nosebleeds
- Sinus problems

Lungs

- Difficulty breathing
- Shortness of breathing
- Persistent cough
- Coughing phlegm
- Coughing blood
- Asthma
- Pneumonia
- Emphysema
- Bronchitis
- Infections

Vascular

- Angina
- Murmurs
- Heart disease
- Chest pain
- Palpitations
- Ankle swelling
- Cold feet/hands
- Leg cramps
- Calf pain
- Varicose veins
- Hypotension
- Hypertension

Gastro-intestinal

- Bloating/gas
- Heartburn
- Ulcers
- Liver disease
- Gall bladder disease
- Vomiting/nausea
- Abdominal pain
- Diarrhea
- Constipation
- Blood in stool
- Hemorrhoids
- Hernias

Urinary

- Difficulty urinating
- Pain urinating
- Blood in urine
- Incontinence
- Bed-wetting
- Urinary urgency
- Frequent urination
- Frequent infections
- Kidney stones

Neurological

- Seizures/epilepsy
- Strokes
- Tingling sensation
- Numbness
- Muscle weakness
- Difficulty walking
- Poor coordination
- Paralysis
- Speech problems
- Loss of memory

Name: _____ DOB: _____

Muscle & Bone

- Joint pain
- Swollen joints
- Stiffness
- Muscle ache
- Foot trouble
- Arthritis
- Bone pain
- Fractures
- Dislocations

Skin

- Rash
- Itching/hives
- Changes in moles
- Acne
- Psoriasis
- Eczema

Endocrine

- Diabetes
- Hypoglycemia
- Hormone therapy
- Thyroid problems
- Heat/cold intolerance
- Excessive thirst
- Excessive hunger
- Excessive sweating
- Night sweats

Emotional

- Depression
- Mood swings
- Anxiety
- Tension
- Phobias
- Alcohol/drug abuse

Conditions

- AIDS/HIV
- Eating disorders
- Heart condition
- Rheumatic arthritis
- Rheumatic fever
- Alcoholism
- Cancer/tumor
- Polio
- Parkinson's
- Multiple sclerosis
- Gout
- Anemia
- Osteoporosis
- Osteoarthritis
- High cholesterol
- Fibromyalgia
- Chronic fatigue
- Hepatitis
- Migraines

Family History

Do you have a family history of any of the following? (Please check)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hives | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Illness | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | |

MUSCULOSKELETAL PROBLEMS

Please describe your pain or problem and its history with relevant details of injuries and treatments:

Problem#1: _____

X-ray or MRI? _____

Results: _____

Name: _____ DOB: _____

Problem#2: _____

X-ray or MRI? _____

Results: _____

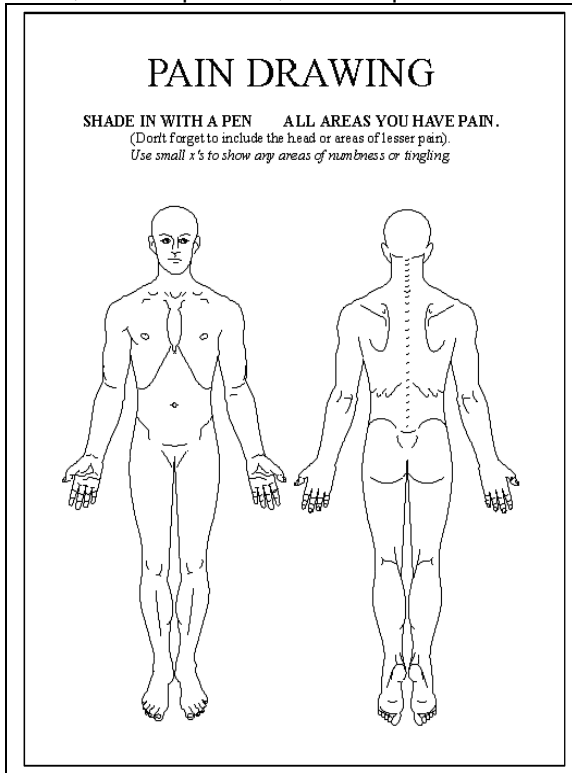
Problem#3: _____

X-ray or MRI? _____

Results: _____

Do you have any of the following?

Please mark: Y=Yes, current or recent problem;
N=No, never a problem; P= Past problem



Headache: Y N P

TMJ Pain: Y N P

Low Back Pain: Y N P

Shoulder Pain: Y N P

Thumb Pain: Y N P

Knee Pain: Y N P

Weakness: Y N P

Arthritis: Y N P

Name: _____ DOB: _____

PATIENT MEDICATION AND SUPPLEMENT SHEET

List all Prescription Medicines that you are taking & include dosage:

Drug	Dosage	How Long	Reason	Side Effects

List all OTC Drugs, Nutrients and Supplements that you are taking & include dosage:

OTC Drugs/Nutrients/Supplements	Dosage	How Long	Reason	Side Effects

Known Allergies

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods or supplements? _____

Are you lactose intolerant? _____

Environmental allergens (animals, dust, pollens)? _____