Sharif Chiropractic Health Centre

3420 Hurontario Street, Suite 306
Mississauga, Ontario, L5B 4A9
905-272-PAIN (7246)

Case History

Name (last) (first)			E-mail Address	Private Insurance Coverage Yes ☐ No ☐
Address			City	Postal Code
Home Phone	Work Phone		Cell Phone	SIN# if WSIB Case
Date Of Birth (dd/mm/yy)	Age	Sex M☐ F☐	Name, Number of Emergency Contact	
Occupation			Employer	Health Card Number if WSIB Case
Marital Status Single ☐ Married ☐ Divorced ☐ Widowed ☐			Spouse's Name	Spouse's Occupation
Do You Have Children? Yes ☐ No ☐			Names and Ages	
Who can we thank for referring you to this office?			Have you seen a Chiropractor before? Yes ☐ No ☐ When _____	Are spinal x-rays available? Yes ☐ No ☐ When _____

About Your Health:

The human body is designed to be healthy. Throughout life, certain events occur which damage your health. This case history will uncover the layers of damage, especially to your nervous system, that resulted in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your health potential.

Current Health Habits:

	Yes	No	Comments
Did/Do you Smoke? Quantity _____	☐	☐	_____
Did/Do you drink alcohol? Quantity _____	☐	☐	_____
Do you eat healthy food?	☐	☐	_____
Have you been in accidents?	☐	☐	_____
Have you had surgery?	☐	☐	_____
Drugs? (Prescription or non prescription)	☐	☐	_____
Grinding teeth or jaw problems?	☐	☐	_____
Exercise regularly?	☐	☐	_____
Do you have occupational stress?	☐	☐	_____
Physical stress?	☐	☐	_____
Mental stress?	☐	☐	_____
Hobbies/Sports Injuries?	☐	☐	_____

Sleeping Posture? Side ☐ Stomach ☐ Back ☐

Number of Pillows? _____

Present State Of Health:

Presently, the years of continuing damage showed up as acute or chronic symptoms.

Present complaint (be brief) _____

Pain or problem started when? _____

Pains are: sharp ☐ dull ☐ constant ☐ intermittent ☐

Have you ever had the same or similar problem? When? _____

Is the condition worse during certain times of the day? When? _____

Is this condition interfering with: work ☐ sleep ☐ family/social life ☐ other ☐
Any home remedies? _____

What medications are you taking? _____

Other symptoms: now or within the past few years

Headaches		Pains/Pins & Needles in Legs		Fainting	
Neck Pain/Stiffness		Pains/Pins & Needles in Arms		Allergies/Asthma	
Sleeping Problems		Numbness in Fingers		Diarrhea/Constipation	
Back Pain		Numbness in Toes		Cold Feet	
Nervousness		Shortness in Breath		Cold Hands	
Tension/Stress		Fatigue		Upset Stomach	
Irritability		Depression		Menstrual Problems	
Chest Pain		Lights Bother the Eyes		Loss of Balance	
Dizziness		Loss of Memory		Convulsions	
Ear Rings or Buzzes		Fever		Bladder/Bowel Problems	
Loss of Smell or Taste		Significant Weight Loss		Stroke	

For Women: Are you pregnant?
Yes ☐ No ☐ Maybe ☐ Date of last menstrual cycle _____

Is There A Family History Of

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Mother's Side	☐	☐	☐	☐	_____
Father's Side	☐	☐	☐	☐	_____

About Your Care:

Chiropractic provides three types of care. The first is the Initial Intensive Care, which corrects the most recent of the Spinal and Neurological damage. This care reduces or eliminates the symptoms. Then begins Reconstructive Care, which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your report of findings. Then you will be able to begin the course of care that fits your health goals.

Patient Signature _____Date: _____