Gleeson Clinic
1304 E. Victoria Ave., Thunder Bay, ON., P7C 1C2
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Patient Health History

☐ Dr. Dana M. Gleeson, B.Sc., (Hons.), D.C.
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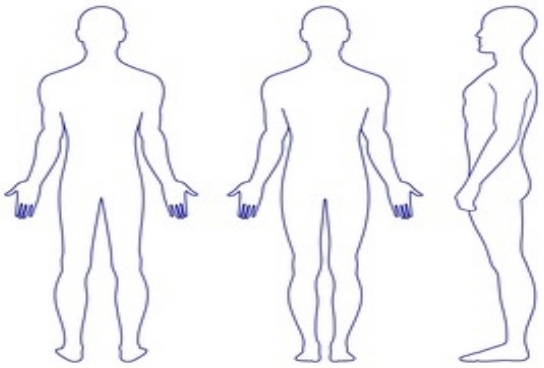
Please answer all questions carefully. This information is essential for your Doctor to assess your total health picture as it relates to your problem(s).

Name: _____ **Date:** _____

Please describe your major complaint(s)and any pain/discomfort associated with it: _____
_____
_____
_____

Please mark on diagram your main areas of complaint



When did this condition begin initially? _____
Have you seen other doctors for this condition? _____
Who? _____
Did you receive treatment for this condition? _____
If so, please explain: _____
_____
What were the results? _____
_____
Were any X-rays/MRIs/CTs or other diagnostic testing done for this condition? _____

Do you have pain radiating/travelling to other areas of the body? _____
If yes, please explain: _____
_____

What movements aggravate you? (*circle one or more)* ***standing sitting bending other***
Have you had this condition before? (*circle one)* **Yes / No** If **Yes**, when? _____
What is the severity of your pain on a scale of 1 to 10? *(10 being the most severe*) _____
How does your condition interfere with:
Your ability to work? _____
Your ability to enjoy your family or social time? _____
Your ability to enjoy your hobbies and sports? _____
Medications being taken: _____
Supplements being taken: _____

Do you have any previous:
☐ childhood traumas ☐ motor vehicle accidents
☐ sports injuries ☐ workplace injuries

Family History:

Do you have a family history of:
☐ strokes ☐ high blood pressure
☐ arthritic conditions ☐ diabetes
☐ cancer ☐ heart conditions
☐ scoliosis ☐ other

Please explain: _____

See over →

Please check any symptoms which you experience:

☐ Headaches	☐ Dizziness	☐ Nervousness
☐ Depression	☐ Insomnia	☐ Fatigue (AM or PM)
☐ Arthritis	☐ Hernia	☐ Heartburn
☐ Belching	☐ Passing gas	☐ Constipation
☐ Loose bowel movements	☐ Gallbladder problems	☐ Eye or vision problems
☐ Hay fever	☐ Hoarseness	☐ Sinus problems
☐ High blood pressure	☐ Low blood pressure	☐ Pain over heart
☐ Swelling of ankles	☐ Poor circulation	☐ Chest pain
☐ Shortness of breath	☐ Acne	☐ Skin rashes
☐ Dry skin	☐ Hyperactivity	☐ Learning disability
☐ Poor appetite	☐ Hemorrhoids	☐ Asthma
☐ Frequent Colds	☐ Bruise easily	☐ Varicose veins
☐ Painful or frequent urination	☐ Bedwetting	☐ Nausea
☐ Allergies	☐ Ear or hearing problems	

Pain, numbness or stiffness in:

☐ neck	☐ hips	☐ knees	☐ feet	☐ hands
☐ legs	☐ arms	☐ shoulders	☐ mid-back	☐ low-back

Men Only: ☐ Prostate problems ☐ Impotence/Loss of sex drive

Women Only: ☐ Menopausal symptoms ☐ Loss of sex drive

☐ Menstrual problems (irregularity, pain, excess flow, moods etc.)

List Doctors and treatment prescribed for any of the above: _____

_____

_____

_____

List all surgeries and year if possible *(include cesarean births):* _____

_____

_____

_____

List all major injuries, accidents or falls *(with year if possible):* _____

_____

_____

Last physical examination: _____ Height: _____ Weight: _____

Last menstrual period: _____ Are you a **SMOKER / NON-SMOKER?** *(circle one)*

Do you smoke: ***Cigarettes Pipe Cigars Other*** How many per day? _____

If you smoked previously, when did you quit? _____

List how many cups per day you drink of: ***coffee _____ decaf coffee _____ tea _____ herbal tea _____ milk _____ soft drinks _____ water _____***

If you drink Alcohol, please list kinds and amounts: _____

Do you exercise regularly? **Yes / No** Type and duration: _____

_____

List hobbies and other activities: _____

_____