Gleeson Clinic
1304 E. Victoria Ave., Thunder Bay, ON., P7C 1C2
Phone: (807) 623-5531 or (807) 622-2132 Fax: (807) 626-9511

Patient Health History

☐ Dr. Dana M. Gleeson, B.Sc., (Hons.), D.C.
☐ Dr. Robert P. Beckford, B.Sc., (Hons.), D.C.
☐ Dr. Barb Stachejczuk, B.Sc., D.C.

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:** _____

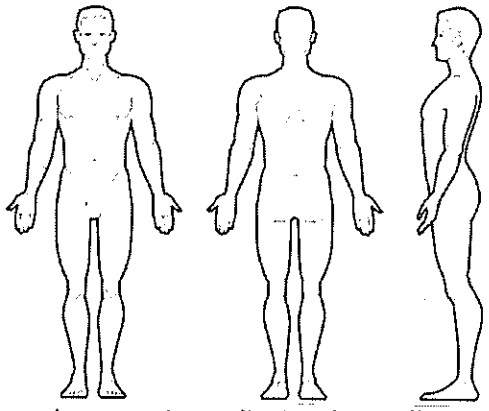
Please describe your major complaint(s)and any pain/discomfort associated with it: _____

_____

_____

_____

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: _____

_____