EHL HEALTH · DR. ELSE HARRISHOJ LARSEN, D.C., CCOS(C) Date______________________

PATIENT INFORMATION

Last Name____
First Name____
Birthdate ____
Medical No____
Referred by____
Occupation____
Sex ☐ Male ☐ Female
E-Mail____
Would you like to receive e-mail reminders? ☐ Yes ☐ No

Address____
____
City____
Province__________________ Postal Code_________________
Cell Phone____
Work Phone____
Home Phone____
Marital Status ☐ S ☐ M ☐ W ☐ D
Spouse's Name____

DO YOU HAVE OR HAVE YOU HAD DIFFICULTY WITH THE FOLLOWING:

If yes, circle **O** for conditions that are 6 months or older, and **N** for conditions that have started in the last 6 months.

1. **O N** Headache
2. **O N** Nausea
3. **O N** Fever
4. **O N** Chills
5. **O N** Sweats
6. **O N** Fainting
7. **O N** Dizziness
8. **O N** Convulsion
9. **O N** Difficulty Sleeping
10. **O N** Fatigue
11. **O N** Nervousness
12. **O N** Poor Appetite
13. **O N** Loss of Weight
14. **O N** Numbness or Pain in Arms, Legs or Hands
15. **O N** Allergy
16. **O N** Excessive Thirst

17. **O N** Vision Problems
18. **O N** Eye Pain
19. **O N** Deafness
20. **O N** Earache
21. **O N** Ear Discharge
22. **O N** Nose Bleeds
23. **O N** Nasal Obstruction
24. **O N** Sore Throat
25. **O N** Hoarseness
26. **O N** Hay Fever
27. **O N** Wheezing
28. **O N** Asthma
29. **O N** Gum Trouble
30. **O N** Frequent Colds
31. **O N** Enlarged Thyroid
32. **O N** Tonsillitis
33. **O N** Sinus Infection
34. **O N** Nasal Drainage
35. **O N** Enlarged Glands

36. **O N** Skin Eruptions
37. **O N** Itching
38. **O N** Bruises Easily
39. **O N** Dryness of Skin
40. **O N** Hives or Allergy
41. **O N** Boils
42. **O N** Varicose Veins
43. **O N** Sensitive Skin

44. **O N** Chronic Cough
45. **O N** Spitting up Phlegm
46. **O N** Spitting up Blood
47. **O N** Chest Pain
48. **O N** Difficult Breathing

49. **O N** Rapid Heart Beat
50. **O N** Slow Heart Beat
51. **O N** High Blood Pressure
52. **O N** Low Blood Pressure
53. **O N** Pain Over Heart
54. **O N** Shortness of Breath
55. **O N** Previous Heart Stroke
56. **O N** Hardening of Arteries
57. **O N** Swelling of Ankles
58. **O N** Poor Circulation
59. **O N** Paralytic Stroke

60. **O N** Stiff Neck
61. **O N** Back Ache
62. **O N** Neck Pain
63. **O N** Swollen Joints
64. **O N** Painful Tail Bone
65. **O N** Foot Problems
66. **O N** Pain in Shoulders
67. **O N** Hernia
68. **O N** Faulty Posture
69. **O N** Arthritis
70. **O N** Muscle Weakness
71. **O N** Any Fractures

72. **O N** Frequent Urination
73. **O N** Painful Urination
74. **O N** Blood in Urine
75. **O N** Pus in Urine
76. **O N** Kidney Infection
77. **O N** Kidney Stones
78. **O N** Bed Wetting
79. **O N** Inability to Control Bladder
80. **O N** Prostate Trouble
81. **O N** Difficult Digestion
82. **O N** Excessive Hunger
83. **O N** Belching or Gas
84. **O N** Vomiting
85. **O N** Vomiting of Blood
86. **O N** Pain Over Stomach
87. **O N** Constipation
88. **O N** Colon Trouble
89. **O N** Hemorrhoids (piles)
90. **O N** Intestinal Worms
91. **O N** Liver Trouble
92. **O N** Colitis
93. **O N** Jaundice

94. **O N** No. of Pregnancies ______
95. **O N** No. of Children _________
96. **O N** Painful Menstruation
97. **O N** Excessive Flow
98. **O N** Hot Flashes
99. **O N** Irregular Cycle
100. **O N** Cramps or Backache
101. **O N** Previous Miscarriage
102. **O N** Vaginal Discharge
103. **O N** Congested Breast
104. **O N** Lumps in Breast
105. **O N** Menopausal Symptoms
106. **O N** Osteopenia/Osteoporosis

107. **O N** HIV Positive

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES:

107. ☐ Appendicitis
108. ☐ Scarlet Fever
109. ☐ Diphtheria
110. ☐ Typhoid Fever
111. ☐ Pneumonia
112. ☐ Rheumatic Fever
113. ☐ Polio
114. ☐ Malaria
115. ☐ Tuberculosis
116. ☐ Whooping Cough
117. ☐ Anemia
118. ☐ Measles
119. ☐ Mumps
120. ☐ Small Pox
121. ☐ Chicken Pox
122. ☐ Diabetes
123. ☐ Cancer
124. ☐ Heart Disease
125. ☐ Goiter
126. ☐ Influenza
127. ☐ Pleurisy
128. ☐ Alcoholism
129. ☐ Venereal Infections or STD's
130. ☐ Epilepsy
131. ☐ Mental Disorder
132. ☐ Eczema
133. ☐ Gout
134. ☐ Arthritis

Any other condition: ____

HAS ANYONE IN YOUR FAMILY HAD ANY OF THE FOLLOWING DISEASES:

135. ☐ Appendicitis
136. ☐ Scarlet Fever
137. ☐ Diphtheria
138. ☐ Typhoid Fever
139. ☐ Pneumonia
140. ☐ Rheumatic Fever
141. ☐ Polio
142. ☐ Convulsion
143. ☐ Difficulty Sleeping
144. ☐ Fatigue

EHL HEALTH · ELSE HARRISHOJ LARSEN, D.C., CCOS(C) Date: ______________________

PATIENT'S CONDITION

145. Is the condition due to a Motor Vehicle Accident or otherwise: ☐ No ☐ Yes
146. Are you claiming under the Workers' Compensation Act: ☐ No ☐ Yes
147. Have you had any treatment for this condition: ☐ No ☐ Yes If **yes**, please indicate type: ____________________________
148. How long has this condition existed: ____
149. What was the original cause of this condition: ____
150. Briefly describe complaint: ____

____

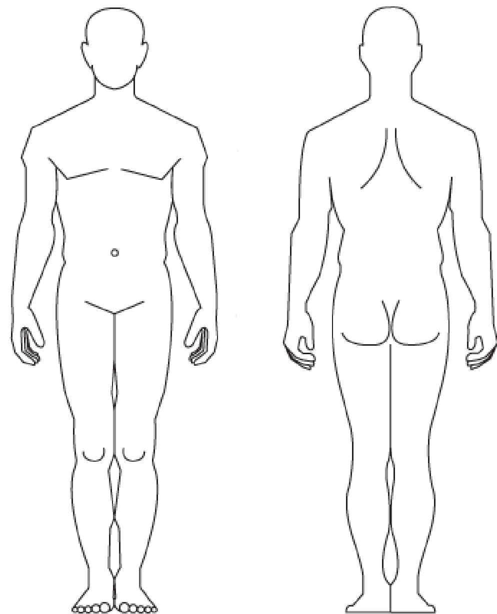
____

151. Have you had X-Rays taken: ☐ No ☐ Yes If **yes**, where: ___________________________ Date taken: (d/m/y)____________
152. Have you had any previous episodes/occurrences of this condition: ☐ No ☐ Yes
    If **yes**, how long ago: (give month and year)____
153. Have you been to a chiropractor before: ☐ No ☐ Yes

PROBLEM AREA

Please indicate problem area(s) by labeling them as:

A = Ache
N = Numbness
P = Pain
T = Tingling
X = Pins & needles



No Pain	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

154. Have you had any falls, accidents, or injuries: ☐ No ☐ Yes
    If **yes**, please explain: (give month and year) ____
155. Have you had surgery: ☐ No ☐ Yes If **yes**, please give type and date: (month and year) ____________________________

____

156. Are you presently taking medication: ☐ No ☐ Yes If **yes**, please give type, dosage and reason: ______________________

____

157. Do you: ☐ Smoke ☐ Drink Alcohol if **yes**, please indicate how often and how much: ______________________________

Signature: ____

If patient is a minor, give name of parent or guardian: ______________________________