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

1. ____ Headache
2. ____ Nausea
3. ____ Fever
4. ____ Chills
5. ____ Sweats
6. ____ Fainting
7. ____ Dizziness
8. ____ Convulsion
9. ____ Difficulty Sleeping
10. ____ Fatigue
11. ____ Nervousness
12. ____ Poor Appetite
13. ____ Loss of Weight
14. ____ Numbness or Pain in Arms, Legs or Hands
15. ____ Allergy
16. ____ Excessive Thirst
17. ____ Vision Problems
18. ____ Eye Pain
19. ____ Deafness
20. ____ Earache
21. ____ Ear Discharge
22. ____ Nose Bleeds
23. ____ Nasal Obstruction
24. ____ Sore Throat
25. ____ Hoarseness
26. ____ Hay Fever
27. ____ Wheezing
28. ____ Asthma
29. ____ Gum Trouble
30. ____ Frequent Colds
31. ____ Enlarged Thyroid
32. ____ Tonsillitis
33. ____ Sinus Infection
34. ____ Nasal Drainage
35. ____ Enlarged Glands
36. ____ Skin Eruptions
37. ____ Itching
38. ____ Bruises Easily
39. ____ Dryness of Skin
40. ____ Hives or Allergy
41. ____ Boils
42. ____ Varicose Veins
43. ____ Sensitive Skin
44. ____ Chronic Cough
45. ____ Spitting up Phlegm
46. ____ Spitting up Blood
47. ____ Chest Pain
48. ____ Difficult Breathing
49. ____ Rapid Heart Beat
50. ____ Slow Heart Beat
51. ____ High Blood Pressure
52. ____ Low Blood Pressure
53. ____ Pain Over Heart
54. ____ Shortness of Breath
55. ____ Previous Heart Stroke
56. ____ Hardening of Arteries
57. ____ Swelling of Ankles
58. ____ Poor Circulation
59. ____ Paralytic Stroke
60. ____ Stiff Neck
61. ____ Back Ache
62. ____ Neck Pain
63. ____ Swollen Joints
64. ____ Painful Tail Bone
65. ____ Foot Problems
66. ____ Pain in Shoulders
67. ____ Hernia
68. ____ Faulty Posture
69. ____ Arthritis
70. ____ Muscle Weakness
71. ____ Any Fractures
72. ____ Frequent Urination
73. ____ Painful Urination
74. ____ Blood in Urine
75. ____ Pus in Urine
76. ____ Kidney Infection
77. ____ Kidney Stones
78. ____ Bed Wetting
79. ____ Inability to Control Bladder
80. ____ Prostate Trouble
81. ____ Difficult Digestion
82. ____ Excessive Hunger
83. ____ Belching or Gas
84. ____ Vomiting
85. ____ Vomiting of Blood
86. ____ Pain Over Stomach
87. ____ Constipation
88. ____ Colon Trouble
89. ____ Hemorrhoids (piles)
90. ____ Intestinal Worms
91. ____ Liver Trouble
92. ____ Colitis
93. ____ Jaundice
94. ____ No. of Pregnancies _____
95. ____ No. of Children _____
96. ____ Painful Menstruation
97. ____ Excessive Flow
98. ____ Hot Flashes
99. ____ Irregular Cycle
100. ____ Cramps or Backache
101. ____ Previous Miscarriage
102. ____ Vaginal Discharge
103. ____ Congested Breast
104. ____ Lumps in Breast
105. ____ Menopausal Symptoms
106. ____ Osteopenia/Osteoporosis
107. ____ 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

Reset

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 labelling them as:

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

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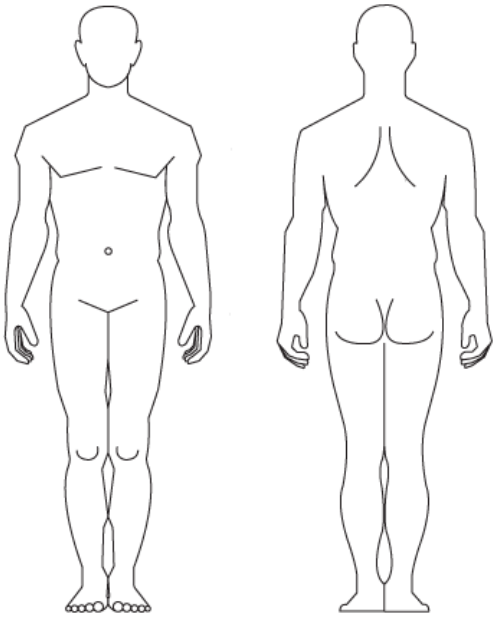

No Pain

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: _____
PHYSICAL SIGNATURE REQUIRED.

If patient is a minor, give
name of parent or guardian: _____
PHYSICAL SIGNATURE REQUIRED.

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