



Dr. Paul Given
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(613) 542-5802
docgiven.getwellstaywell@gmail.com

Patient Name: _____ **ID#** _____

New Patient Health History

Please answer what you can before your visit. Skip anything you are unsure of; we can discuss it together. Most people finish in about five minutes.

About you

Name _____

Date of birth _____ Mobile _____ Email _____

Preferred contact: ☐ Text ☐ Call ☐ Email Emergency contact and phone

Occupation or main daily activity _____ Referred by

What brings you in

Your main concern and what you hope to be able to do again

When did it begin? _____ How did it start? _____

Where is it? _____ Current intensity 0–10: _____ Worst 0–10: _____

How often? ☐ Constant ☐ Daily ☐ Some days ☐ Occasional

What makes it worse? _____ What helps? _____

Other concerns you would like us to know about:

How is this affecting your life

Select only the activities affected, then rate the overall impact.

☐ Sleep ☐ Sitting or driving ☐ Standing or walking ☐ Bending or lifting ☐ Work

☐ Exercise or sport ☐ Family or recreation ☐ Concentration ☐ Other _____

Overall impact: ☐ Mild, I can do most things ☐ Moderate, I modify activities ☐ Severe, I cannot do important activities

Health and safety



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Have you had a recent fall, accident or major injury? ☐ No ☐ Yes:

Prior spine or joint injury, surgery or treatment that may matter? ☐ No ☐ Yes:

Major diagnoses (for example cancer, heart disease, stroke, diabetes, osteoporosis): ☐ No ☐ Yes: _____

Current medicines, blood thinners, steroids or relevant allergies: ☐ None ☐ Details:

Are you pregnant or could you be pregnant? ☐ No ☐ Yes ☐ Unsure ☐ Not applicable

Any other health concern, previous care, or family history you want Dr. Given to know about:

Symptoms you may not have thought to mention

Check any you currently experience. We will ask about timing and details if relevant.

- ☐ Headaches ☐ Dizziness or balance changes ☐ Numbness or tingling ☐ Weakness
☐ Jaw pain ☐ Neck or back pain ☐ Arm or leg pain ☐ Joint pain ☐ Sciatica
☐ Sleep trouble ☐ Brain fog or concentration ☐ Anxiety or mood changes ☐ Fatigue
☐ Digestive or bowel changes ☐ Bladder changes ☐ Vision or hearing changes ☐ Other _____

Anything urgent or worsening, including new bowel or bladder control changes or progressive weakness, should be reported directly to the clinician.