

Date: _____

E-mail: _____

Personal Information

Name: _____ Address: _____
 City: _____ Province: _____ Postal Code: _____
 Home phone #: _____ Date of Birth: _____ Gender: M ___ F ___
 Business/Employer _____ Type of work _____
 Business phone # _____ Emergency contact _____
 Cell Phone# _____ Relationship _____
 Referred by: _____ Reason for contacting our office: _____
 What is your primary complaint? _____

Your Health Profile

Why This Form is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us profiles of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to health potential.

The Beginning Years (To Age 17)

Research is showing that most of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	Yes	No	Unsure		Yes	No	Unsure
Did you have any childhood illnesses?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Did you suffer any other traumas? (physical or emotional)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have any serious falls as a child?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Were you delivered: Vacuum	<input type="radio"/>		
Did you play youth sports?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Forceps	<input type="radio"/>	C-section	<input type="radio"/>
Did you take/use any drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Mom induced	<input type="radio"/>	Naturally	<input type="radio"/>
Did you have any surgery?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Unsure	<input type="radio"/>		
Have you fallen/jumped from a height over three feet? (i.e.: crib, bunk bed tree)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Was there any prolonged use of medicine such as antibiotics or an inhaler ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Were you involved in any car accidents as a child?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	As a child, were you under regular chiropractic care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Adult Years (Age 18 to present)

	Yes	No		Yes	No
Do/did you smoke?	<input type="radio"/>	<input type="radio"/>	Do/did you participate in extreme sports?	<input type="radio"/>	<input type="radio"/>
Do/did drink alcohol?	<input type="radio"/>	<input type="radio"/>	Did you have any impacts?	<input type="radio"/>	<input type="radio"/>
Have you been in any car or work related accidents? If so was your nerve system checked by a chiropractor afterwards?	<input type="radio"/>	<input type="radio"/>	Do/did you play contact sports?	<input type="radio"/>	<input type="radio"/>
Have you had any surgery?	<input type="radio"/>	<input type="radio"/>	If so did you have your spine and nerve system checked regularly by a chiropractor?	<input type="radio"/>	<input type="radio"/>
What kind? _____	<input type="radio"/>	<input type="radio"/>	Rate your stress level on the scale 1-10 (1-none, 10-severe)		
			Personal _____ Occupational _____		

Please indicate any other traumas, impacts, collisions, and other injuries have you had _____

Please check ALL of the following you might have EVER had even if you don't think they are related to the current problem:

- Arthritis
- Herniated Disc
- Numbness / tingling
- Depression
- Pain between shoulders
- Pinched nerve
- Chronic infections
- Low back/hip pain
- Low back/hip pain
- Walking problems
- Heart/vascular problems
- Frequent/ nausea
- Ulcers/ heartburn
- Diabetes
- Pain/stiff in mornings
- Diarrhoea / constipation
- Thyroid problems
- Upset stomach
- Mood swings
- Asthma/allergies
- Shortness of breath
- Buzzing/ringing in ears
- Liver/gall bladder problems
- Osteoporosis
- Bladder trouble/ painful urination
- Cancer of _____
- Menstrual irregularity
- Sexual dysfunction
- Blood pressure trouble
- Ankle swelling
- Decreased immunity/ frequent colds
- Menstrual Cramps Miscarriage(s)
- Chest pains / heart disease

List all medications you are taking and what for: _____

For women: Are you pregnant? Yes__ No__ Trying__ Unsure__ Date of last menstrual period: _____

If you have no specific symptoms or complaints, and are here mainly for wellness services, please check (x) here_____ and skip to “**Family Health Profile**”.

If you have symptoms or complaints need to briefly describe the chief area of complaint, including the affect it has had on your life. _____

Please list **medications** are you taking for this condition: _____

If you are experiencing pain: In the scale from 1-10 (10 being the worst) rate here 1...2...3...4...5...6...7...8...9...10

What type: **Sharp** **Dull** **Comes & Goes** **Travels** **Constant**

Since the problem started it is: **About the Same** **Getting better** **Getting Worse**

What makes it worse: _____

It Interferes with: **Work** **Sleep** **Walking** **Sitting** **Hobbies** **Leisure**

Names of other Doctors seen for this problem:

Chiropractor _____

Medical Doctor _____

Other _____

Please rate your level of commitment to resolving this/these problem(s) (10 being the highest)

1 2 3 4 5 6 7 8 9 10

If it's not 10, What stops you from full commitment? _____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have. Your Family may be eligible for a **free** spinal check up.

Childrens Names: _____

Spouses Name: _____

Mother/Father: _____

Brother(s)/Sister(s): _____

Others: _____

Patient Signature _____ Date _____