Your Confidential Health Profile

Patient #:_____ Date:_____

Personal Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr. .Name:_____

How do you wish to be addressed in our office? _____

Birth Date:_____ ☐ Male ☐ Female

Address: _____

City/Province/Postal Code_____

Home Phone: _____ Work Phone: _____Mobile Phone:_____

E-mail Address: _____

Occupation: _____ Hobbies:_____

☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse or Partner's Name:_____

Children's Names & Ages: _____

Previous Chiropractor/RMT: _____ Last Visit: _____

How did you hear about our office? _____

Please mark an "X" where you believe your health is today, and an "O" where you would like to be.

For professional's use only. Please continue on the next page.

New Practice Member health objectives:

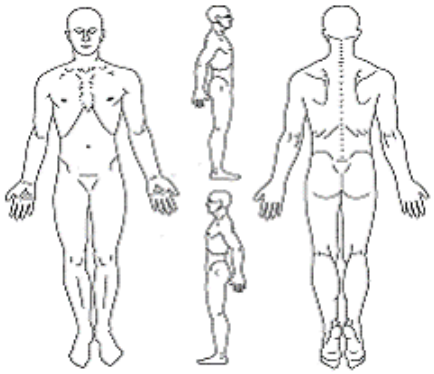
- ☐ Temporary Relief Only
- ☐ Correction and Prevention
- ☐ Optimal Health

Current Health Profile

Health Concerns: List according to Their severity:	Severity: 1= mild 10= worst	When did this episode start?	If you've had this condition before, when?	Are symptoms constant or intermittent?
1._____	___	_____	_____	_____
2._____	___	_____	_____	_____
3._____	___	_____	_____	_____
4._____	___	_____	_____	_____

Using the appropriate letter from the legend below, please mark any and all areas where you feel pain, numbness, spasm, tenderness or any other sensation that is unusual or abnormal:

Aching – AA
Burning – BB
Cramps – CC
Dull – DD
Muscle Spasm – MM
Numbness – NN
Pins & Needles - PN
Sharp - SP
Shooting - SH
Stabbing – SB
Stiffness – ST
Swelling - SW
Throbbing - TT



Please briefly describe your chief concern, including the effect it has had on your life: _____
_____

_____

Does the pain travel/radiate anywhere? ☐No ☐Yes - please describe: _____

Since the problem started, is it: ☐About the same ☐Getting Better ☐Getting Worse

What makes it worse?_____

What have you done that has helped you feel better? _____

What have you done for it that was of NO help?_____

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Exercise/Walking/Sports ☐ Hobbies

☐Positive Mental Attitude, ☐ Other:_____

Other Health Care Professionals seen for this condition:

Name/Profession:	Date:	Diagnosis:	Treatment:	Results:
1._____	_____	_____	_____	_____
2._____	_____	_____	_____	_____

Were x-rays taken? ☐ No ☐ Yes Area of body:_____ Date: _____

Current Medications & Supplements:_____

General Health Profile

Please check all symptoms you have ever had, even if they do not seem related to your current problem. For all symptoms that you check, please also indicate P for Past and C for Current.

□ Neck pain	□ Pins and needles in arms	□ Low back pain	□ Allergies
□ Headaches	□ Numbness in fingers	□ Pins and needles in legs	□ Loss of smell
□ Lights bother eyes	□ Shoulder pain	□ Numbness in toes	□ Loss of taste
□ Dizziness	□ Mid back pain	□ Loss of balance	□ Sinus trouble
□ Fainting	□ Chest pain	□ Urinary problem	□ Fatigue
□ Loss of concentration	□ Heartburn	□ Foot trouble	□ Cold sweats
□ Buzzing in ears	□ Difficulty breathing	□ Stomach upset	□ Hot flashes
□ Earache	□ Sleeping problems	□ Constipation	□ Depression
□ Nervousness	□ Cold hands	□ Diarrhea	□ Irritability
□ Tension	□ Cold feet	□ Skin conditions	□ Mood swings
□ Frequent colds	□ Leg/foot pain	□ Anxiety/stress	□ Infertility
□ Nausea	□ Heart problems	□ Fever	□ Tension
□ TMJ pain/stiffness	□ Hip pain	□ Arm/hand pain	□ Brain fog
□ Erectile dysfunction	□ Focus & memory issues	□ Unexplained weight loss	□ ADD/ADHD
□ Epilepsy/seizures	□ High blood pressure	□ Unexplained weight gain	□ Joint pain

Women Only: Are you pregnant? □ Yes □ No

□ Menstrual Pain	□ Cramps/backache	□ Irregular menstruation	□ Excessive flow
□ Abnormal discharge	□ Passed menopause	□ Birth control pill	□ Hysterectomy
□ Intra-uterine device	□ Tubal ligation	Date of last period: _____	

What Do You Want?

If we were meeting here 3 years from today – and you were looking back over those 3 years to today, what has to have happened during that period concerning your health, for you to feel happy about your progress?

What are the 3 biggest things holding you back from achieving the level of health you want?

Stress Profile

Chronic physical, chemical and emotional stress is the cause of most health problems. Please review these common stresses and circle when you experienced it in your life. Use P for Past and C for Current. Your answers will help enable us to determine what contributed to your present health.

Physical Stress:

		Explanation:
1. Forceps, suction extraction, or caesarean delivery	P C	_____
2. Accidents (auto, work related, falls or other)	P C	_____
3. Surgical operations	P C	_____
4. Strains, sprains, and/or broken bones	P C	_____
5. Poor posture (excessive computer work, driving)	P C	_____
6. Poor sleeping habits	P C	_____
7. Repetitive movements	P C	_____
8. Sports injuries	P C	_____
9. Heavy lifting and/or bending	P C	_____
10. Overweight	P C	_____
11. Lack of exercise	P C	_____

Chemical Stress:

1. Take prescription or over-the-counter medication	P C	_____
2. Consume alcohol	P C	_____
3. Consume caffeine (coffee, tea, pop)	P C	_____
4. Use tobacco products	P C	_____
5. Use artificial sweeteners (aspartame, sucralose)	P C	_____
6. Poor diet (fast food, white flour, white sugar)	P C	_____
7. Environmental pollution	P C	_____
8. Overweight	P C	_____

Emotional Stress:

1. Divorce of parents or spouse	P C	_____
2. Death of a loved one	P C	_____
3. Serious illness (self or a loved one)	P C	_____
4. Financial concerns	P C	_____
5. Procrastination	P C	_____
6. Worry and/or fear	P C	_____
7. Work environment	P C	_____
8. Relationships	P C	_____
9. Anger by you or at you	P C	_____
10. Low self-esteem	P C	_____

Our goal is to provide the safest and most effective care possible. In order to do so, it is important that we perform a series of tests. I consent to a complete examination as the doctor deems necessary.

Signature: _____ Date: _____

Signature: _____ Date: _____