SOURCE CENTRE
HEALTH IN WHOLENESS

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326 Adelaide Street West, Suite 202, Toronto, ON, M5V1R3

Last Name: ______________________________

First Name : _____________________________

Address : ____

City/Prov: _________________________________ Postal Code : ______________________

Best phone number to reach you at: _______________________ Cell/Home/Work

2nd Best number to reach you at : ________________________ Cell/Home/Work

Can we leave a message at best number? Y ☐ N ☐ 2nd best? Y ☐ N☐

E-mail Address :______________________________________

Would you like to receive our Lifesource Email Newsletter? Y ☐ N☐

Date of Birth (mm/dd/yy) :____/____/____ Gender:_________________

Marital Status :

Single ☐ Coupled ☐ Married/Common Law ☐ Divorced ☐ Widowed ☐

Please list spouse/partner children (same or different address) and others living at the same address

First Name	Last Name	Age	Relationship	Same Address?

Occupation/Title:_________________ Who is your current employer?__________________

How did you find out about Source Center or from whom? _______________________________

What is your present motivation for consulting our office?

- ☐ Heal disease, symptoms and infirmities
- ☐ Preventing disease, symptoms and infirmities
- ☐ Improving family and/or community health
- ☐ Maximizing personal health potentials

Medical History

Date and reason for last visit to medical doctor: (symptoms, diagnosis, treatment, outcome)

____

Please list any current medications/supplements that you are currently taking

____

Please list any medications used in the past for more than three months and their purpose

____

Have you or anyone in your extended biological family had any previous significant health issues? (i.e. heart disease/stroke, cancer, diabetes, infections) ? Please describe and indicate relationship.

____

Current Concerns

What is your reason for seeking our services? ______________________

What concerns do you have about your health and well being? Please list in order of importance.

____

____

Please answer the following questions ONLY with respect to your MOST important concern:

In what part of your body do you experience your pain/symptoms? ______________________

Does your pain/symptom travel to anywhere else in your body? Y ☐ N ☐

If Yes, where?____

What does this pain/symptom feel like? Please check any that apply:

Sharp ☐ Stabbing ☐ Dull ☐ Achy ☐ Numbness ☐ Tingling ☐ Burning ☐

Cold ☐ Pins & Needles ☐ Electricity ☐ Other (specify): ______________

When did this pain/symptom begin? ______________________________

What happened? ____

How has the pain/symptom changed over time? Worse ☐ Better ☐ No Change ☐

How often does this pain/symptom occur? ___________________________

When your pain/symptom is present, how long does it last? ________________________

On the scale below, please mark the level of pain you most consistently feel, with 0 being no pain and 10 being the worst pain you can imagine.

|____|

0 **10**

What makes this pain/symptom better? ____

What makes this pain/symptom worse? ____

Are there any other related or associated concerns? _________________________________

Have you ever experienced this pain/symptom or something similar in the past? Y ☐ N ☐

If Yes, please describe ____

Have you sought advice or treatment from a health professional? Y ☐ N ☐ If Yes, what were you told? ____

What was done? ______________________________________ **Did it seem to work? Y ☐ N ☐**

History of Stresses

Please indicate any of these that apply to you.

Show past stressors by underlining, show current ones by circling.

Traumatic Events

Slips Falls Car Accidents Injury Broken Bones/Fractures Surgeries Sprains Contact Sports

Repetitive Stressors

Lifting Bending Carrying Computer work Standing/Sitting for long periods Long drives

Chemical Stressors

Smoking 2nd Hand Smoke Vaccinations OTC Drugs Recreational Drugs Alcohol Caffeine

Refined Sugar Artificial Sweeteners Occupational Environmental Substance Abuse

Mental/Emotional Stressors

Relationships Family Children/Dependants Emotional/Sexual Abuse Divorce/Separation

Loss of loved One Change in Residence Change in Career Work School Fast-paced Life

Internalized Feelings Quick Temper Perfectionist Procrastinator Financial Illness

Birth History

Home ☐ Hospital ☐ Forceps ☐ Caesarean section ☐ Other Trauma: ________________

Health and Lifestyle

Is there anything about your Nerve System and Spine that we should know about? What are your concerns? ____

Have you been to a Chiropractor before? Y ☐ N ☐ If Yes, when, why did you go, what was done, what did you enjoy about your experience? _____________________________________

Please indicate your participation in the following vehicles of growth, healing and development:

Show past participation by underlining and current participation by circling.

Chiropractic massage yoga pilates chelation homeopathy naturopathy acupuncture ayuvrvedic medicine Qi Gong Tai Chi meditation music therapy herbalist psychotherapy rebirthing breathwork movement therapy energywork nutritional therapy osteopathy prayer church cranial work herbs supplements

When stressed, how do you "centre" yourself or "re-group"? _____________________________________

Is there some aspect of your life that very much pleases you, brings you joy or helps you to feel good about yourself? ____

On a scale of 1 (Low) to 10 (High), please rate the following:

Current Life Stress ______ Level of Health ______ Overall Life Happiness _____

How many hours of sleep do you get? _____ What is the quality? Low ☐ Med ☐ High ☐

Please rate your:	Great	OK	Dissatisfied
Ability to Fall Asleep	☐	☐	☐
Experience of Vitality	☐	☐	☐
Alertness and Clarity	☐	☐	☐
Level of Energy `	☐	☐	☐

Yesterday, what did you choose to eat for Breakfast? ________________ Lunch? ____________________

Snack? ________________ Dinner? ____________________ What is your daily fluid intake? ______________

Please rate your:	Great	OK	Dissatisfied
Mental Focus and Concentration	☐	☐	☐
Weight and Body Image	☐	☐	☐
Digestive Function	☐	☐	☐
Bowel Movement and Urination	☐	☐	☐

How much or what kind of physical activity do you get? ____
Are you training? Y ☐ N ☐ If Yes, please explain ____________________________________
What type of work do you do, activities and responsibilities
____

Please rate your:	Great	OK	Dissatisfied
Balance, Coordination	☐	☐	☐
Physical Flexibility	☐	☐	☐
Physical Endurance	☐	☐	☐
Physical Strength	☐	☐	☐

What do you do for play and relaxation? ____

When was your last vacation? ____

Please rate your:	Great	OK	Dissatisfied
Time for Self	☐	☐	☐
Work and Career	☐	☐	☐
Financial Situation	☐	☐	☐
Connectedness with Others	☐	☐	☐
Intimate Relationship(s)	☐	☐	☐

Your Needs and Hopes for Care

In a published study of over 2,800 participants in Network Spinal Analysis, the participants reported an overall improvement in several categories of health and wellness listed below.

Please indicate how you hope to benefit from care in this office:

	Definitely	Would be Nice	Unimportant
Improvement of physical symptoms	☐	☐	☐
Improvement of emotional/mental symptoms	☐	☐	☐
Improvement of my ability to react/respond to stress	☐	☐	☐
Improvement in enjoyment of life/ ability to make constructive choices	☐	☐	☐
Overall improved quality of life	☐	☐	☐

What is your commitment to yourself, your life and well-being on a scale of 1 to 10, where 1 is no commitment and 10 is "will do whatever it takes"? __________

Are there particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook etc. that you feel may *impair* your opportunity for full vitality and health? ____

Are there any factors and elements mentioned above that you feel *give you an edge or add* to your health?____

Is there anything else that may help in understanding you, your history or your professional needs which have not been discussed on this survey?____

____

Thank you for completing these forms and for choosing the Source Center!