NETWORK chiropractic.ca
Dr. Allison Barriscale, D.C., B.Sc.
Dr. Robert Coddington, D.C., B.Sc.H.
450 Bronte St S #212, Milton ON L9T 8T2

Date: _____

1. Contact Information

Please complete the following to help us serve you. Please Print.

First Name _____ Last Name _____

Birthday Month _____ Day _____ Year _____ Gender _____

Address _____

City, Province _____ Postal Code _____

Email _____

Best phone to reach you: _____ Cell ☐ Home ☐ Work ☐ Leave a message? Y ☐ N ☐

Second best phone: _____ Cell ☐ Home ☐ Work ☐ Leave a message? Y ☐ N ☐

How did you find out about us? _____

2. Emergency Contacts

Emergency Contact: _____ Telephone _____

Medical Doctor: _____ Telephone: _____

3. Living Situation

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

How many people do you live with? _____ (adults) _____ (children and/or dependents)

Occupation _____ Hours per week _____ Do you like your work? Y ☐ N ☐

4. Global Well-Being Scale

Please reflect on your **sense of well-being**, taking into account your physical, mental, emotional, social, and spiritual condition ***over the past month***. Use an **X** on the line to mark your answer to the question.

Mark the line below with an **X** at the point that summarizes your **overall sense of well-being** *for the entire month*.

_____

Worst you have ever been — Best you have ever been

5. What are your main health concerns?

☐ I am interested in wellness care (no symptoms)

Concerns: (Please list them in order of importance, from most important to least.) **Date concern began:**

1. _____ _____
2. _____ _____
3. _____ _____

_____

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6. PRIMARY Current Symptom

Please answer the following questions with respect to <u>THE PRIMARY CURRENT SYMPTOM</u>

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 the pain/symptom feel like? Please check any that apply:

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

Cold ☐ Pins & Needles ☐ Electricity ☐ Other: _____

When did this pain/symptom begin? _____

What happened? _____

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

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 the pain/symptom better? _____

What makes the 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 treatment from a health professional? Y ☐ N ☐ If Yes, what were you told? _____

_____

What was done? _____

Did it seem to work? Y ☐ N ☐ Any additional comments and/or insights? _____

_____

Has anyone in your family ever experienced a similar symptom? Y ☐ N ☐ If Yes, please describe:

_____

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7. Wellness & Lifestyle

On a scale of 1 (low) to 10 (high), please rate the following:

Level of energy_____ Current life stress _____ Level of health_____ Overall life happiness _____

Do you usually wake up feeling refreshed? Y ☐ N ☐ Hours of sleep per night: _____

Any problems falling asleep? _____

Sleep position: Back ☐ Right Side ☐ Left Side ☐ Front ☐ Number of times waking at night: _____

Yesterday, what did you eat for: Breakfast_____ Lunch_____

Snacks_____ Dinner_____

What is your daily fluid intake: _____ # of bowel movements/day: _____

How much and what physical activity do you get? _____

What type of work do you do (activities & responsibilities)? _____

What do you do for play and relaxation? _____

How many weeks of holiday do you take each year? _____

What is your future vision for yourself? _____

_____

When stressed, how do you 'centre' yourself or 're-group'? _____

_____

Religion or Personal Philosophy: _____

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

_____

_____

Please rate your satisfaction with the following:

	Great	Okay	Dissatisfied		Great	Okay	Dissatisfied
Experience of vitality	☐	☐	☐	Physical strength	☐	☐	☐
Alertness & clarity	☐	☐	☐	Physical endurance	☐	☐	☐
Level of energy	☐	☐	☐	Emotions & feelings	☐	☐	☐
Mental focus & concentration	☐	☐	☐	Quality of self talk	☐	☐	☐
Weight and body image	☐	☐	☐	Time for self	☐	☐	☐
Digestive function	☐	☐	☐	Connectedness with others	☐	☐	☐
Balance & coordination	☐	☐	☐	Work and career	☐	☐	☐
Physical flexibility	☐	☐	☐	Financial situation	☐	☐	☐

_____

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8. Previous Healthcare Experiences

Have you been to a Chiropractor before? Y ☐ N ☐ if yes, when? _____

What was done, what did you gain? _____

_____

Is there anything about your Nerve System and Spine that we should know about? Y ☐ N ☐ If Yes, describe:

_____

Other approaches or healthcare providers tried: _____

_____

9. History of Life Stresses

Please indicate any of the following that apply to you.

Birth History (your birth)

Home ☐ Birthing Centre ☐ Hospital ☐ Induced ☐ Forceps ☐ Vacuum ☐ Caesarean section ☐

Show past stressors by underlining, show current stressors 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 Flights

Chemical Stressors:

Smoking 2nd Hand smoke Vaccinations Flu shot OTC drugs Recreational drugs Alcohol Caffeine

Refined sugar Artificial sweeteners Occupational Environmental Substance Abuse

Mental / Emotional Stressors:

Relationships Family Children/Dependents Emotional abuse Sexual abuse Divorce/Separation

Loss of loved one Change in residence Change in career Work School Financial Fast-paced life

Internalized feelings Quick temper Perfectionist Procrastinator Illness

Other physical/emotional traumas and scars:_____

_____

_____

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10. Systems Review & Medical Information

Have you **RECENTLY** had the following?

General
- ☐ Tire Easily, weakness
- ☐ Marked weight change
- ☐ Night sweats
- ☐ Persistent fever
- ☐ Sensitivity to heat
- ☐ Sensitivity to cold

Skin
- ☐ Eruptions (rash)
- ☐ Change in colour
- ☐ Change in hair
- ☐ Change in fingernails

Eyes
- ☐ Trouble seeing
- ☐ Eye pain
- ☐ Inflamed eyes
- ☐ Double vision
- ☐ Wear corrective lenses

Ears
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Discharge

Nose
- ☐ Loss of smell
- ☐ Frequent colds
- ☐ Obstruction
- ☐ Excess drainage
- ☐ Nosebleeds

Mouth
- ☐ Sore gums
- ☐ Soreness of tongue
- ☐ Dental problems

Throat
- ☐ Postnasal drainage
- ☐ Soreness
- ☐ Hoarseness

Breasts
- ☐ Lumps
- ☐ Discharge

Cardiorespiratory system
- ☐ Cough, persistent
- ☐ Sputum (phlegm)
- ☐ Bloody sputum
- ☐ Wheezing
- ☐ Chest pain or discomfort
- ☐ Pain on breathing while lying down
- ☐ Swelling of ankles
- ☐ Bluish fingers or lips
- ☐ High blood pressure
- ☐ Palpitations
- ☐ Vein trouble

Digestive system
- ☐ Change in appetite
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Abdominal distress
- ☐ Belching or excess gas

Digestive system (cont.)
- ☐ Abdominal enlargement
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Rectal bleeding
- ☐ Tarry stools
- ☐ Dark urine
- ☐ Jaundice
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Need for laxatives

Genitourinary system
- ☐ Increase in frequency of urination (day)
- ☐ Increase in frequency of urination (night)
- ☐ Feel need to urinate without much urine
- ☐ Unable to hold urine
- ☐ Pain or burning
- ☐ Blood in urine
- ☐ Albuminuria
- ☐ Impotence
- ☐ Lack of sex drive
- ☐ Pain with intercourse

Endocrine system
- ☐ Thyroid challenges
- ☐ Adrenal challenges

Endocrine system (cont.)
- ☐ Cortisone treatment
- ☐ Diabetes

Motor system
- ☐ Muscle cramps
- ☐ Muscle weakness
- ☐ Pain in joints
- ☐ Swollen joints
- ☐ Stiffness
- ☐ Deformity of joints

Nervous system
- ☐ Headache
- ☐ Dizziness
- ☐ Fainting
- ☐ Convulsions or fits
- ☐ Nervousness
- ☐ Sleeplessness
- ☐ Depression
- ☐ Change in sensation
- ☐ Memory loss
- ☐ Poor coordination
- ☐ Weakness or paralysis

OB/GYN

Days between periods_____

Duration of periods: _____

Flow: ☐ normal ☐ light ☐ heavy

☐ Pain with periods

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

_____

Any allergies and/or asthma: _____

Have you **AND/OR anyone in your extended family** experienced any previous significant health issues? (heart disease stroke, cancer, diabetes, infections) _____

_____

_____

Please list any current medications/supplements and any used for longer than three months, and their purpose:

_____

_____

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11. 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 tell us 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	☐	☐	☐
Ability to make constructive choices	☐	☐	☐
Improved enjoyment of life	☐	☐	☐
Overall improved quality of life	☐	☐	☐

12. Understanding where you're at

Please mark the following statement that you feel best describes your current feelings about yourself and your situation.

☐ I feel helpless, like little or nothing works.

☐ I feel terrible, really bad, I am scared, and hope you can fix me.

☐ I feel stuck, and I can't help myself right now.

☐ I deserve more than what I've been experiencing and would like you to assist me in my healing.

What is your commitment to yourself, your life and wellbeing on a scale of 1 to 10, where 1 is no commitment and 10 is will do whatever it takes"? _____/10

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 or elements, as 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 that has not been captured on this form? _____

_____

_____

_____

_____