



### 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

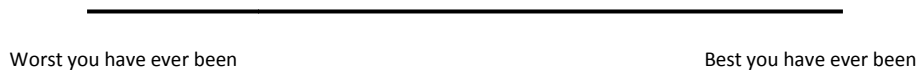
How many people do you live with? \_\_\_\_\_ (adults) \_\_\_\_\_ (children and/or dependents)

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.



### 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. \_\_\_\_\_

\_\_\_\_\_



## 6. PRIMARY Current Symptom

### Please answer the following questions with respect to THE PRIMARY CURRENT SYMPTOM

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? \_\_\_\_\_

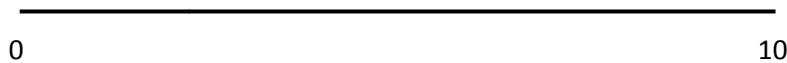
What happened? \_\_\_\_\_

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.



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:

\_\_\_\_\_



## 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical strength	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alertness & clarity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical endurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotions & feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental focus & concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Quality of self talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight and body image	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Time for self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestive function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Connectedness with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance & coordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work and career	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical flexibility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Financial situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



## 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 2<sup>nd</sup> 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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



### 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 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: \_\_\_\_\_



## 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improvement of emotional/mental symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improvement of my ability to react/respond to stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to make constructive choices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Improved enjoyment of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overall improved quality of life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 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? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_