

Why this form is important: - As a family wellness-oriented chiropractic office, we focus on helping you maximally express your health potential. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health. Most times, the effects are so gradual that they are not felt until they become serious. Our first goal is to locate any & all interference to the full outward expression of that potential & address the issues that brought you here. In addition, we hope to offer you & your family the opportunity for a lifetime of health, wellness & vitality through chiropractic care. Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better assess your current status & more accurately determine what course of care will best help you reach your true health potential.

PERSONAL AND FAMILY HEALTH HISTORY

Today's Date: _____

Name: _____ Date of Birth (mm/dd/yyyy): _____ (Age _____)

Address: _____ Sex: F M BC Health Card #: _____

City: _____ Prov.: _____ Postal: _____ Are you or might you be pregnant? Yes No

Phone: (H) _____ (W) _____ Occupation: _____

Email: _____ Employer: _____

Referred by: _____ Spouse's Name: _____

of Children: Names, Ages: _____

GROWTH & DEVELOPMENT (Childhood Years: Ages 0-17 years)

Did you ever...

Have any serious falls or accidents? Y / N _____
Have recurrent childhood illness/sickness? Y / N _____
Experience other serious traumas/stress? Y / N _____

CURRENT HEALTH HABITS (Adult Years: Ages 18 to present)

Do you...

Eat healthy foods regularly? Y / N _____
Drink 8-10 cups of water daily? Y / N _____
Exercise regularly? Y / N _____
Smoke? Y / N _____
Have high mental stress? Y / N _____
Have high physical stress? Y / N _____
Have any serious or chronic past injuries? Y / N _____
Have sleeping problems? Y / N _____

Sleeping position: side; stomach; back _____
Have you been in car accidents? Y / N _____ When? _____

Was Your Birth Traumatic? (Circle if you know...)
Long delivery? Y / N
Difficult delivery? Y / N
Forceps / vacuum extractor? Y / N
Caesarian section? Y / N
Breach/cephalic? Y / N
Mother given drugs/epidural during birth? Y / N
Induced labour? Y / N

FAMILY HEALTH PROFILE - Please mark if you have a family history of:

Table with columns: Arthritis, Cancer, Diabetes, Heart Disease, High Blood Pressure, Strokes, Other. Rows: Your father's side, Your mother's side, Your children/siblings.

MEDICAL INFO: Who is your medical doctor? _____

If you are taking medications, please list them.

Med: _____ For what? _____ For how long? _____
Med: _____ For what? _____ For how long? _____
Med: _____ For what? _____ For how long? _____
Other: _____

What side effects have you experienced from the drugs &/or surgery? _____

If you have had any surgeries, please list them.

Surgery: _____ For what? _____ Date? _____
Surgery: _____ For what? _____ Date? _____
Surgery: _____ For what? _____ Date? _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

Have you been to a chiropractor before? Y / N If yes, who have you seen? _____
 If yes, for what? _____ When was your last adjustment? _____

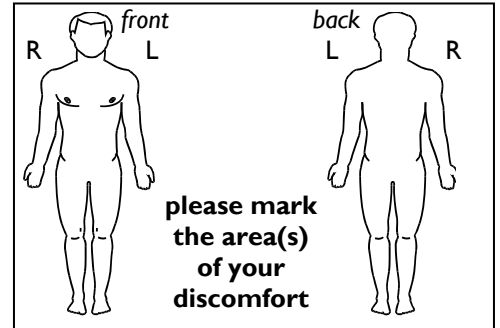
*** If you have no symptoms or complaints and you are here for wellness care, please check here:
 I wish to have Chiropractic Wellness Services
 & skip to the **CURRENT SYMPTOMS** section near the bottom of this form. Otherwise, please continue.

Present Complaint (Reason for your visit today):

Pain or problem started how and when? _____

What activities make your condition / pain worse? _____

What activities make your condition / pain better? _____



If you have pain, is it...
 sharp dull radiating constant intermittent
 mild moderate mod-severe severe

Since it began, is it...
 the same variable getting better getting worse

What time of day is worst?
 waking at work evening
 at night variable constant

Does it interfere with...
 work sleep walking
 sitting exercise other _____

Are there other doctors / treatments that you have tried for this problem? (Please list.)

massage therapist _____ physiotherapist _____
 acupuncturist _____ medical doctor _____
 other _____

OTHER TESTS: (please circle)

Have you ever had:
 X-rays / CT scan / MRI
 of your :
 Neck / Back / Hips/pelvis

If yes, how long ago?
 <7 years, > 7yrs

Do you remember what the results were? _____

CURRENT SYMPTOMS (even if they do not seem related to your current condition):

- | | | | |
|----------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> headaches / migraines | <input type="checkbox"/> dizziness / vertigo | <input type="checkbox"/> sinus problems / allergies | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> neck stiffness / pain | <input type="checkbox"/> fatigue | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> heart problems / stroke |
| <input type="checkbox"/> shoulder stiffness / pain | <input type="checkbox"/> sleeping problems | <input type="checkbox"/> constipation / diarrhea | <input type="checkbox"/> cancer |
| <input type="checkbox"/> pins & needles in arms | <input type="checkbox"/> tension / stress | <input type="checkbox"/> problems urinating | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> numbness in fingers | <input type="checkbox"/> nervousness / anxiety | <input type="checkbox"/> cold sweats | <input type="checkbox"/> recurring infection |
| <input type="checkbox"/> back stiffness / pain | <input type="checkbox"/> irritability / mood swings | <input type="checkbox"/> hot flashes | <input type="checkbox"/> loss of smell / taste |
| <input type="checkbox"/> pins & needles in legs | <input type="checkbox"/> depression | <input type="checkbox"/> menopause | <input type="checkbox"/> vision changes |
| <input type="checkbox"/> numbness in feet / toes | <input type="checkbox"/> stomach upset | <input type="checkbox"/> PMS / menstrual cramps | <input type="checkbox"/> buzzing / ringing in ears |
| <input type="checkbox"/> foot problems | <input type="checkbox"/> heartburn / reflux | <input type="checkbox"/> infertility / impotence | <input type="checkbox"/> loss of balance |
| <input type="checkbox"/> jaw / TMJ problems | <input type="checkbox"/> ulcers | <input type="checkbox"/> cold hands / feet | <input type="checkbox"/> chest pains |
| <input type="checkbox"/> other _____ | | | |

RESULTS:

As a result of my chiropractic care, I would like to: (Please check all that apply)

- Feel better quickly** **Live a healthier lifestyle**
 Have a healthier spine **Learn about a healthier lifestyle**
 Have a healthier body by keeping my nerve system healthy

 Signature

 Date

On a daily basis, we all experience physical, chemical, & emotional stresses that can accumulate & result in serious loss of health potential.

At the **New West Wellness Centre**, we will help to find & treat these effects.

Chiropractic helps your entire body – for a healthier life & spine!