

Lifestyle Health Centre

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Date (mm/dd/yy): _____/_____/_____

Name: _____

Address: _____ City: _____ Prov: _____ Postal Code: _____

Phone #: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

BC Care Card #: _____ Birthdate: _____

Email: _____ @ _____

EMERGENCY CONTACT

Relationship: _____ Name: _____ Cell Phone: _____

ACCIDENT INFORMATION

Is your condition due to an accident? Yes No If yes, please report to front desk for additional forms

To whom have you reported the accident? ICBC WCB Employer Other: _____

How did you find our clinic? Check one:

Friend/Co-worker Current Patient Name: _____ Internet Yellow Pages

WHY THIS FORM IS IMPORTANT

On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime and presently, allowing us to better assess the challenges to your health potential.

YOUR HEALTH PROFILE

Have you received chiropractic spinal adjustments by a Doctor of Chiropractic? Yes No

If yes, what was the doctor's name and when was your last visit? _____

Why did you stop going? _____

HEALTH/TRAUMA/MEDICAL TREATMENT

Do you have an M.D. and when was the date of your last examination? _____

Have you ever been hospitalized or had surgery? Yes No Explain: _____

Who is your Dentist and when was the date of your last examination? _____

Have you ever had Physiotherapy? Yes No

Do we have your permission to send reports to any of the above Medical/Health Professionals? Yes No

YOUR WELLNESS GOALS

What are your health goals? _____

Do you have any current symptoms or health concerns that brought you to our office? Yes No Wellness care/advice

If yes, please describe: _____

When did this situation or concern begin? _____

Is there any time of day or a specific activity which makes you aware of it? _____

Have you done anything about this situation or concern, or gotten any advice or treatment? Yes No

What was done to help you? _____

Please grade the level to which this symptom or health concern affects these aspects of your functioning/quality

0 – It does not seem to affect me at all

2 – It seems to moderately affect me

1 – It seems to slightly affect me

3 – It seems to drastically affect me

Effect on work _____

Effect on walking _____

Effect on rest/sleep _____

Effect on eating _____

Effect on exercise _____

Effect on sitting _____

Other stressors throughout our life impact our body's ability to adapt and function. Please take a moment to consider the impact of past or current stresses.

PHYSICAL STRESS

Have you experienced any of the following? If so please indicate if this happened in the past or is a current or ongoing concern

AND also indicate the severity of the concern.

Birth Trauma Past Present / Mild Significant

Sports Past Present / Mild Significant

Vehicle Accidents Past Present / Mild Significant

Work Injuries Past Present / Mild Significant

CHEMICAL STRESS

Are you CURRENTLY taking any medications? If yes please specify name and purpose _____

Have you taken any medications regularly in the past? Yes No

Do you smoke or have you in the past? Yes No

Please indicate if you consume any of the following using this scale:

D- Consume daily

W – Consume weekly

M – Consume monthly

N – Never consume

_____Coffee _____Artificial Sweeteners _____Soda Pop _____Dairy _____Refined Sugar

EMOTIONAL STRESS

How would you grade your emotional/mental health? (Circle) **Excellent** **Good** **Fair** **Getting Better** **Getting Worse**

Do you have any of the following stressors? Please indicate if this was in the past or is current **AND** the severity.

- Childhood Stress Past Present / Mild Significant
- School Stress Past Present / Mild Significant
- Personal Relationships Past Present / Mild Significant
- Stress from an Illness Past Present / Mild Significant
- Work Related Stress Past Present / Mild Significant
- Change in Lifestyle Past Present / Mild Significant
- Abuse Past Present / Mild Significant

Chiropractic care affects all aspects of health and wellness, please rate how each of the following 5 categories applies to you:

3) Very Important To Me 2) Important To Me 1) Not So Important To Me 0) Does Not Apply

- _____Improvement of my physical symptoms
- _____Improvement of emotional/mental symptoms
- _____Improvement of my ability to react to or respond to stress
- _____Improvement in enjoyment of life and the ability to make constructive decisions
- _____Overall improved quality of life

Is there anything else that may help us to understand you, your history, or your specific needs, which have not been discussed on this health profile?

Please indicate with an X all symptoms that you have experienced within the past 6 months:

HEAD:

- Headache
 - Sinus (allergy)
 - Entire head
 - Back of head
 - Forehead
 - Temples
 - Migraine
- Head feels heavy
- Loss of memory
- Fainting
- Light bothers eyes
- Blurred vision
- Double vision
- Loss of vision
- Loss of balance
- Loss of taste
- Loss of hearing
- Dizziness
- Pain in ears
- Ringing or noises in ears

NECK:

- Pain in neck
- Neck pain with movement
 - Forward
 - Backward
 - Turning (L or R)
 - Bending (L or R)
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasms in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

SHOULDERS:

- Pain in joint (L or R)
- Pain across shoulders
- Bursitis (L or R)
- Arthritis
- Can't raise arm
 - Above shoulder level
 - Overhead
- Tension in shoulders
- Pinched nerve in shoulder(L or R)
- Muscle spasms in shoulder

ARMS AND HANDS:

- Pain in arm
- Tennis elbow
- Pain in hands/fingers (L or R)
- Pins and needles sensation (L or R)
- Numbness (L or R)

- Hands cold
- Loss of grip strength
- Sore/Swollen joints in fingers
- Arthritis in fingers

MIDBACK:

- Mid-back pain
- Pain between shoulder blades
- Sharp stabbing
- Dull ache
- Muscle spasms
- Pain in kidney area

CHEST:

- Chest pain
- Shortness of breath
- Rib pain
- Breast pain
- Irregular heartbeat

ABDOMEN:

- Nervous stomach
- Food I can't eat
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK:

- Lower back pain (L or R)
 - Upper lumbar
 - Lower Lumbar

Low back pain is worse when:

- Working
- Lifting
- Standing
- Sitting
- Bending
- Coughing
- Lying down
- Walking

Pain is relieved when:

- _____
- Slipped disc
- Low back feels out of place
- Muscle spasm
- Arthritis

HIPS, LEGS, & FEET

- Pain in buttocks(L or R)
- Pain in hip joint(L or R)
- Pain down leg (L or R)

- Knee pain (L or R)
 - Outside
 - Inside
- Leg cramps
- Feet cramps
- Pins and needles in legs
- Numbness in legs/feet
- Swelling in legs/feet

GENERAL:

- Nervousness
- Irritable
- Depressed
- Fatigue
- Run-down feeling
- Normal sleep Hrs ____
- Loss of sleep
- Loss of weight lbs ____
- Weight gain lbs ____
- Coffee ____cups/day
- Tea ____cups/day
- Cigarettes ____pks/day
- Diabetes
- Hypoglycemia
- Numbness
- Tingling
- Other _____

How you feel is a poor judge of your health. Most people are suffering from ill health even before symptoms appear. Vertebral Subluxations (spinal nerve interference) can occur in your spine for decades even before symptoms occur, interfering with the proper functioning of the body's most vital organs causing your body to eventually dysfunction and breakdown.