Lifestyle Health Centre

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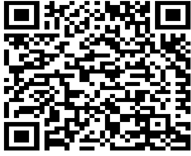

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Date (mm/dd/yy):__/___/ _____

Name: ____

Address: ______________________________City: __________Prov: _____Postal Code: __________________

Phone #: Home: (_____)________________Work: (____) ______________ Cell: (_____)______________

I prefer to be contacted at: ☐ Home ☐ Work ☐ Cell ☐ Email Sex: ☐ M ☐ F

Email:______________________ BC Care Card # _________

Birth Date (mm/dd/yy) ___/____/____ Occupation: ____

☐ Single ☐ Married ☐ Common Law ☐ Divorced ☐ Widowed Name of Spouse: ___________________________

# of Children: _____ Names and Ages:____

EMERGENCY CONTACT

Relationship: ________________ Home Phone: ________________ 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 Name: ________________________________ ☐ Internet ☐ Yellow Pages ☐ Clinic Signage

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? ______________________________

How long were you receiving chiropractic adjustments? ______________________________________

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

If yes, who is/was your Physiotherapist and how long were you under care for? _____________________

Do you have a Naturopath? ☐ Yes ☐ No

If yes, who is your naturopath and when was the date of your last visit? __________________________

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? ______________________________

What are your health objectives in consulting with Lifestyle Chiropractic? ______________________________

What are your objectives regarding your health once you feel your symptom/concern is dealt with?

____

YOUR HEALTH CONCERNS OR SYMPTOMS AND HOW THEY MAY AFFECT YOUR LIFE

Do you have any current symptoms or health concerns that brought you to our office? ☐ Yes ☐ No ☐ Wellness care/advice If yes, please describe (the quality – achy, sharp, dull; duration – constant, occasional; pain – into legs or arms; anything that makes it better or worse) ______________________________

When did this situation or concern begin? ______________________________

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

Is there any time of day or a specific activity when you totally or almost totally forget about this condition, symptom, or concern?

____

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

What was done to help you? ______________________________

Did it seem to work? ______________________________

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**

Affect on work ____ Affect on recreation/play ____ Affect on rest/sleep ____ Affect on exercise ____
Affect on walking ____ Affect on social life ____ Affect on eating ____ Affect on sitting ____

Please grade the concern about this problem as it relates to your overall health (scale of 0-3) ____

Why do you think this happened or continues to happen? ______________________________

Do you think that there are other factors involved? ☐ Yes ☐ No

If yes, what else do you think is involved? ______________________________

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 Explain: ______________________________

Falls ☐Past ☐Present / ☐Mild ☐Significant Explain: ______________________________

Vehicle Accidents ☐Past ☐Present / ☐Mild ☐Significant Explain: ______________________________

Work Injuries ☐Past ☐Present / ☐Mild ☐Significant Explain: ______________________________

Sports (either repetitive or specific incidents) ☐Past ☐Present / ☐Mild ☐Significant Explain: ____________________

____

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	Explain: ______________________
School Stress	☐Past	☐Present	/	☐Mild	☐Significant	Explain: ______________________
Personal Relationships	☐Past	☐Present	/	☐Mild	☐Significant	Explain: ______________________
Stress from an Illness	☐Past	☐Present	/	☐Mild	☐Significant	Explain: ______________________
Work Related Stress	☐Past	☐Present	/	☐Mild	☐Significant	Explain: ______________________
Change in Lifestyle	☐Past	☐Present	/	☐Mild	☐Significant	Explain: ______________________
Abuse	☐Past	☐Present	/	☐Mild	☐Significant	Explain: ______________________

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

a) _____Improvement of my physical symptoms

b) _____Improvement of emotional/mental symptoms

c) _____Improvement of my ability to react to or respond to stress

d) _____Improvement in enjoyment of life and the ability to make constructive decisions

e) _____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? ____

How did you hear about our office? ☐ Friend ☐ Family ☐ Neighborhood ☐ Other: ______________________________

If you were referred in to our office, whom can we thank for referring you? ______________________________________

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.

FEE SCHEDULE

Due to the decision of the BC Government regarding health care benefits, supplementary health care coverage for chiropractic care has been eliminated for most British Columbians.

Our fees are as follows:

Service	Fee
Initial Consultation and Exam	$ 65.00
Subsequent Visit	$ 45.00
Initial Visit Students	$ 50.00
Subsequent Visit Students	$ 40.00
Initial/Subsequent Visit Children (5 years and under)	$ 40.00
Initial Visit Seniors (65+)	$ 50.00
Subsequent Visit Seniors (65+)	$ 40.00
X-Ray (One Section)	$ 50.00
X-Ray (Full Spine)	$ 100.00
Prescription Orthotics (Gait Scan and report included)	$ 425.00
Laser Treatment	$ 45.00
Laser Treatment and Adjustment	$ 70.00

Packages Currently Available:

Package	Treatments	Price
Chiropractic Package	12 treatments + 2 complementary	**$ 540.00**
Laser Package	12 treatments + 2 complementary	**$ 540.00**
Laser & Chiro Package	12 treatments + 2 complementary	**$ 840.00**

($20.00 bank fee for cheques returned NSF)

MSP BENEFITS

Some patients are covered under partial MSP. Please hand your Care Card to the Receptionist at the front desk as she can check to see if you have coverage.

AUTHORIZATION

Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any payment that is not covered by the Medical Services Plan or other parties including ICBC and WCB. This form allows the deposit of cheques made payable to the patient for office visits to be deposited.

______________________	______________________	______________________
Patients Name (Please Print)	Patients Signature/Parent or Guardian if minor	Date

Witness Initial __________