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Lifestyle Health Centre

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Date (mm/dd/yyyy):_____/___/ _____

Name: _____

Address: _____City:_____ Prov:_____ Postal Code: _____

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

BC Care Card #: _____ Birthdate: _____

Height: _____ Weight: _____

Email: _____@_____

Occupation: _____

EMERGENCY CONTACT:

Relationship: _____ Name: _____ Cell Phone: _____

*** ACCIDENT INFORMATION ***

Is your condition due to an accident being claimed? □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 ☐ Sign

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 a Medical Doctor? If yes what is their name 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** **R – Rarely** **N – Never consume**

Coffee____ Artificial Sweeteners____ Soda Pop____ Dairy____ Refined Sugar____ Alcohol___

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?

_____

_____

_____

Is there someone you know that may also benefit from chiropractic care? If so please provide their name and contact information and we would be happy to set up an appointment for them:

_____

_____

_____

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)
- ☐ R) Pins and needles sensation (L or R)
- ☐ 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
- ☐ Pain in hip joint (L or
- ☐ 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.