

## GENERAL INFORMATION

Today's Date: \_\_\_\_\_

Name (as it is shown on your Care card) \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_ Care card # \_\_\_\_\_  
Home # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_ Ext# \_\_\_\_\_ Cell # ( ) \_\_\_\_\_  
Cell # ( ) \_\_\_\_\_ Email address: \_\_\_\_\_ *\*please note - we ask for your email address as part of your contact information. We occasionally will email you about your appointments and events in our office. As with all your personal information we keep this information private at all times.*

Occupation \_\_\_\_\_ Employer's Name \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ Prov \_\_\_\_\_  
Male  Female  # of Children \_\_\_\_\_ Single  Married  Divorced  Widowed   
Name of Spouse \_\_\_\_\_ Names of children \_\_\_\_\_  
Who can we thank for referring you to our office? \_\_\_\_\_  
Purpose of your visit today \_\_\_\_\_  
Was this due to:  car accident  injury  other: \_\_\_\_\_  
Are you currently on an ICBC claim?  Yes  No  
If so, what is your ICBC Claim # \_\_\_\_\_ Adjusters Name \_\_\_\_\_  
Adjusters Phone # \_\_\_\_\_ Adjusters Email \_\_\_\_\_  
Adjusters Email address \_\_\_\_\_

### Your Health Profile

**WHY THIS FORM IS IMPORTANT:** As a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a lifetime of health, happiness and vitality. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious and sometimes not until it's too late! 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 and more accurately determine your true health potential.

**THE BEGINNING YEARS** – Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

**BIRTH HISTORY – Please check all that apply.**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Mother smoked/drank/drugs during pregnancy | <input type="checkbox"/> Epidural/Med's in Labor | <input type="checkbox"/> Breech                 |
| <input type="checkbox"/> C-Section                                  | <input type="checkbox"/> Forceps Delivery        | <input type="checkbox"/> Vacuum Extraction Used |
| <input type="checkbox"/> Complications                              | <input type="checkbox"/> Other: _____            | <input type="checkbox"/> Labor Induced          |

**CHILDHOOD YEARS (0-17 yrs) – Please check all that apply.**

- |   |  |   |  |  |
|---|--|---|--|--|
| <input type="checkbox"/> Childhood illness                | <input type="checkbox"/> Serious Falls | <input type="checkbox"/> Active in sports | <input type="checkbox"/> Very Inactive           | <input type="checkbox"/> Car Accident(s) |
| <input type="checkbox"/> Surgery/Stitches                 | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Smoker           | <input type="checkbox"/> Antibiotics             | <input type="checkbox"/> Drug Abuse      |
| <input type="checkbox"/> OTC Medications                  | <input type="checkbox"/> Vaccinated    | <input type="checkbox"/> Broken Bones     | <input type="checkbox"/> Under Chiropractic Care |  |
| <input type="checkbox"/> Severe Emotional Trauma(s) _____ |  |   |  |  |

**ADULT YEARS (Age 18 to Present) – Please check all that apply.**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Present Smoker   | <input type="checkbox"/> Former Smoker         | <input type="checkbox"/> OTC Medications      | <input type="checkbox"/> Prescription Medications |
| <input type="checkbox"/> Alcohol Use      | <input type="checkbox"/> Surgery/Stitches      | <input type="checkbox"/> Play Sports          | <input type="checkbox"/> Car Accidents            |
| <input type="checkbox"/> Work Injury      | <input type="checkbox"/> High Job Stress       | <input type="checkbox"/> High Personal Stress | <input type="checkbox"/> Poor/Inadequate Diet     |
| <input type="checkbox"/> Sit a lot        | <input type="checkbox"/> Drive a lot           | <input type="checkbox"/> Wear Orthotics/Lifts | <input type="checkbox"/> Severe Health Problems   |
| <input type="checkbox"/> Not enough sleep | <input type="checkbox"/> Poor sleep            | <input type="checkbox"/> No Exercises         | <input type="checkbox"/> Flat feet                |
| <input type="checkbox"/> Broken Bones     | <input type="checkbox"/> Other injuries: _____ |   |   |

Have been under chiropractic care in the past – How long ago was your last adjustment? \_\_\_\_\_

(Turn over please)

## ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

\*\*If you have no symptoms or complaints and you are here for wellness/preventative care please check here  
 **WISH TO HAVE WELLNESS SERVICES** and skip to **FAMILY HEALTH PROFILE** at the bottom of this form.

CHIEF COMPLAINT (S) \_\_\_\_\_

How has this affected your life? \_\_\_\_\_

If you have pain, is it...  Sharp  Dull  Constant  Intermittent  Traveling

Mild  Severe  Intolerable  Radiating  Moderate

Since it began, is it...  About the same  Getting better  Getting Worse  Variable

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Does it interfere with...  Work  Sleep  Walking  Sitting  Exercise  Hobbies  Leisure Activity

Did you have an injury?  No  Yes, please explain: \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Is there a time of day that is worse typically?  No  Yes, when? \_\_\_\_\_

Other doctors/treatments you've tried for this problem (please list):

Chiropractor(s) \_\_\_\_\_

Medical Doctor(s) \_\_\_\_\_

Other(s) \_\_\_\_\_

How has this other treatment been working for you? \_\_\_\_\_

**\*\*PLEASE CHECK ALL RECURRING OR SEVERE SYMPTOMS YOU HAVE EVER HAD, EVEN IF THEY SEEM UNRELATED TO YOUR CURRENT**

### **PROBLEM:**

Headaches/Migraines  Pins & Needles in legs/feet  Recurring Infection  Infertility/Impotence/Miscarriage

Pins & Needles in arms  Loss of smell  Back stiffness/pain  Loss of balance

Dizziness/vertigo  Buzzing/ringing in ears  Sinus Problems/Issues  Nervousness/Anxiety

Numbness in fingers  Numbness in toes  Loss of taste  Stomach Upset

Fatigue  Depression  Tension/Stress  Irritability/Mood Swings

Sleeping Problems  Neck stiffness/pain  Cold hands  Cold Feet

Diarrhea/Constipation/Gas  Foot Problems  Shortness of breath  Hot Flashes

Cold Sweats  Light bothers eyes  Problems urinating  Heartburn/Acid reflux

High Blood Pressure  Pre-Menstrual Syndrome  Menopause  Ulcers

Jaw/TMJ Problems  Other: \_\_\_\_\_

**FAMILY HEALTH PROFILE** – In our office, we are not only interested in your health & well being, but also that of your family and loved ones. Please mention any health conditions or concerns you may have about your:

CHILDREN \_\_\_\_\_

SPOUSE \_\_\_\_\_

PARENTS \_\_\_\_\_

SIBLINGS \_\_\_\_\_

OTHERS \_\_\_\_\_

Have you ever:

Bought Bottled Water?  Yes  No

Belonged to a Health Club?  Yes  No

Consumed Vitamins/Supplements?  Yes  No

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. If the office accepts assignment of benefits under an insurance plan, the Patient (I) will remain primarily responsible for all bills and shall be obligated to pay any and all sums not actually paid by the insurance carrier. I agree to allow this office to examine me for further evaluation.

\_\_\_\_\_

\_\_\_\_/\_\_\_\_/\_\_\_\_

Signature

Today's Date

discover  
chiropractic  
live your best life

Today's Date: \_\_\_\_\_

List Your Pains/Complaints from Most Severe (1) to Least Severe (4)

|   | 1 (Most Severe)  | 2  | 3  | 4 (Least Severe)   |
|---|--|--|--|--|
| Today, you have the following physical complains:                                   | _____  | _____  | _____  | _____  |
| Is this complaint: Sharp, Dull, Achy, Throbbing, Numb, Shooting or other? (explain) | <input type="checkbox"/> Sharp<br><input type="checkbox"/> Dull<br><input type="checkbox"/> Achy<br><input type="checkbox"/> Throbbing<br><input type="checkbox"/> Numb<br><input type="checkbox"/> Electric/Shooting    | <input type="checkbox"/> Sharp<br><input type="checkbox"/> Dull<br><input type="checkbox"/> Achy<br><input type="checkbox"/> Throbbing<br><input type="checkbox"/> Numb<br><input type="checkbox"/> Electric/Shooting    | <input type="checkbox"/> Sharp<br><input type="checkbox"/> Dull<br><input type="checkbox"/> Achy<br><input type="checkbox"/> Throbbing<br><input type="checkbox"/> Numb<br><input type="checkbox"/> Electric/Shooting    | <input type="checkbox"/> Sharp<br><input type="checkbox"/> Dull<br><input type="checkbox"/> Achy<br><input type="checkbox"/> Throbbing<br><input type="checkbox"/> Numb<br><input type="checkbox"/> Electric/Shooting    |
| How often do you feel this complaint? Constant, Daily, Off & On, Weekly?            | <input type="checkbox"/> Constant<br><input type="checkbox"/> Daily<br><input type="checkbox"/> Off & On<br><input type="checkbox"/> Weekly<br><input type="checkbox"/> Monthly<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Constant<br><input type="checkbox"/> Daily<br><input type="checkbox"/> Off & On<br><input type="checkbox"/> Weekly<br><input type="checkbox"/> Monthly<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Constant<br><input type="checkbox"/> Daily<br><input type="checkbox"/> Off & On<br><input type="checkbox"/> Weekly<br><input type="checkbox"/> Monthly<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Constant<br><input type="checkbox"/> Daily<br><input type="checkbox"/> Off & On<br><input type="checkbox"/> Weekly<br><input type="checkbox"/> Monthly<br><input type="checkbox"/> Other: _____ |
| How long have you had this?   | _____  | _____  | _____  | _____  |
| Is it getting better, worse, or staying the same?                                   | <input type="checkbox"/> Better<br><input type="checkbox"/> Worse<br><input type="checkbox"/> Same   | <input type="checkbox"/> Better<br><input type="checkbox"/> Worse<br><input type="checkbox"/> Same   | <input type="checkbox"/> Better<br><input type="checkbox"/> Worse<br><input type="checkbox"/> Same   | <input type="checkbox"/> Better<br><input type="checkbox"/> Worse<br><input type="checkbox"/> Same   |
| What makes it better?   | _____  | _____  | _____  | _____  |
| What makes it worse?  | _____  | _____  | _____  | _____  |
| On a scale of 1-10, rate your discomfort.   | Circle one<br><u>10 9 8 7 6 5 4 3 2 1 0</u><br>10 = Excruciating<br>0 = No Discomfort  | Circle one<br><u>10 9 8 7 6 5 4 3 2 1 0</u><br>10 = Excruciating<br>0 = No Discomfort  | Circle one<br><u>10 9 8 7 6 5 4 3 2 1 0</u><br>10 = Excruciating<br>0 = No Discomfort  | Circle one<br><u>10 9 8 7 6 5 4 3 2 1 0</u><br>10 = Excruciating<br>0 = No Discomfort  |
| How have you taken care of this in the paste How has it worked for you              | _____  | _____  | _____  | _____  |

live your best life

|  |  |  |  |  |
|--|--|--|--|--|
| This issue is affecting my:                              | <input type="checkbox"/> Job <input type="checkbox"/> Childcare<br><input type="checkbox"/> Marriage <input type="checkbox"/> Sex<br><input type="checkbox"/> Golf <input type="checkbox"/> Finances<br><input type="checkbox"/> Playing with children<br><input type="checkbox"/> Bowels <input type="checkbox"/> Urine | <input type="checkbox"/> Job <input type="checkbox"/> Childcare<br><input type="checkbox"/> Marriage <input type="checkbox"/> Sex<br><input type="checkbox"/> Golf <input type="checkbox"/> Finances<br><input type="checkbox"/> Playing with children<br><input type="checkbox"/> Bowels <input type="checkbox"/> Urine | <input type="checkbox"/> Job <input type="checkbox"/> Childcare<br><input type="checkbox"/> Marriage <input type="checkbox"/> Sex<br><input type="checkbox"/> Golf <input type="checkbox"/> Finances<br><input type="checkbox"/> Playing with children<br><input type="checkbox"/> Bowels <input type="checkbox"/> Urine | <input type="checkbox"/> Job <input type="checkbox"/> Childcare<br><input type="checkbox"/> Marriage <input type="checkbox"/> Sex<br><input type="checkbox"/> Golf <input type="checkbox"/> Finances<br><input type="checkbox"/> Playing with children<br><input type="checkbox"/> Bowels <input type="checkbox"/> Urine |
| Helping this issue would increase my quality of life by: | <input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40%<br><input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80%<br><input type="checkbox"/> 90% <input type="checkbox"/> 100%   | <input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40%<br><input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80%<br><input type="checkbox"/> 90% <input type="checkbox"/> 100%   | <input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40%<br><input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80%<br><input type="checkbox"/> 90% <input type="checkbox"/> 100%   | <input type="checkbox"/> 10-20% <input type="checkbox"/> 30-40%<br><input type="checkbox"/> 50-60% <input type="checkbox"/> 70-80%<br><input type="checkbox"/> 90% <input type="checkbox"/> 100%   |

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\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature Today's Date

**Family Plans**

Over 70% of our patients bring in their children to get adjusted. If you would like to have your children and or spouse checked for Subluxations check the box below and they can each receive a complimentary consultation including a computerized surface EMG, if scheduled within 2 weeks of the date you start care. We have affordable family plan payment options should family members decide to receive care.

Has your spouse or child(ren) complained about back, neck, shoulder ache pain in the last 3 years?

I would like my family members checked for Subluxations within the next 2 weeks.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature Today's Date

**IMPORTANT – PLEASE READ AND SIGN BELOW:**

Given the high demand for care and limited appointment times our office requires a full business day's (excluding holidays and days our office is closed) notice of any cancellation or change to your appointments otherwise a cancellation fee may apply. This gives us the chance to try to fill this time slot and help someone else who may desperately need the care. Your cooperation and respect of this policy is greatly appreciated.

I have read and acknowledge the above cancellation policy and know that I am responsible for paying the cancellation fee should I not provide the office with a full business day's notice of any changes to my appointment times.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature Today's Date