PERSONAL & CONFIDENTIAL INFORMATION

Last Name: _____First Name: _____
Sex: M / F Home Phone:_____ Business Phone:_____
Home Address:_____
City:_____ Postal Code: _____
Date of Birth:_____ Occupation:_____ Employer:_____
Marital Status:_____ Name of Spouse:_____ Number of Children:_____
By whom were you referred?_____ Alberta Health Care Number:_____
Other Health Insurance:_____
Reason for consulting our office?_____
In order to inform you of important office changes periodically, please provide us with your email address which will remain confidential:_____

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a full spectrum chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

THE BEGINNING YEARS (TO AGE 17)

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

Your Childhood Years	**YES**	**NO**	**UNSURE**	**COMMENTS:**
Did you have any childhood illnesses?	☐	☐	☐	_____
Did you have any serious falls as a child?	☐	☐	☐	_____
Did you play youth sports?	☐	☐	☐	_____
Did you take/use drugs?	☐	☐	☐	_____
Did you have any surgeries?	☐	☐	☐	_____
Have you fallen/jumped from a height over 3 feet? (crib,bed,trees,bunk)	☐	☐	☐	_____
Was there any prolong use of medicine such as antibiotics or an inhaler?	☐	☐	☐	_____
Did you suffer any other traumas (physical or emotional)	☐	☐	☐	_____
Were you vaccinated?	☐	☐	☐	_____
As a child, were you under regular chiropractic care?	☐	☐	☐	_____
Adult (18 to present)				
Do/did you smoke?	☐	☐	☐	_____
Do/did you drink alcohol?	☐	☐	☐	_____
Have you been in any accidents? (ie,car)	☐	☐	☐	_____
Have you had any surgery?	☐	☐	☐	_____
Do/did you play any adult sports?	☐	☐	☐	_____
Do/did you participate in extreme sports?	☐	☐	☐	_____
Have you had previous chiropractic care?	☐	☐	☐	_____

On a scale of 1 – 10 describe your stress level: (1=none / 10=extreme) Occupational_____ Personal_____

On a scale of Poor, Good, Excellent describe your:
Diet:_____ Exercise:_____Sleep:_____GeneralHealth:_____

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children_____
Spouse_____
Mother_____
Father_____
Siblings_____

Others_____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you have no symptoms or complaints, and are here for wellness services, please check ( ) here____ "**Wish to have Chiropractic Wellness Services"**. Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

_____
_____

If you are experiencing pain, is it…

☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

Since the problem started, it is… ☐ About the same ☐ Getting better ☐ Getting worse

Is this condition related to a work injury? Yes No Has your employer been notified? Yes No

Yes, it interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem (please list)

☐ Chiropractor _____
☐ Medical Doctor _____
☐ Other _____

Please check ( ) all symptoms you have ever had, even if they do not seem related to your current problem.

☐Headaches	☐Pins & needles in legs	☐ Fainting	☐Neck pain
☐Pins & needles in arms	☐Loss of smell	☐Back pain	☐Loss of balance
☐Dizziness	☐Buzzing in ears	☐Ringing in ears	☐Nervousness
☐Numbness in fingers	☐Numbness in toes	☐Loss of taste	☐Stomach upset
☐Fatigue	☐Depression	☐Irritability	☐Tension
☐Sleeping problems	☐Neck stiff	☐Cold hands	☐Cold feet
☐Diarrhea	☐Constipation	☐Fever	☐Hot flashes
☐Cold sweats	☐Light bothers eyes	☐Problem urinating	☐Heartburn
☐Mood swings	☐Menstrual pain	☐Menstrual irregularity	☐Ulcers

List any medications or vitamins you are taking _____

Because we believe optimum health in an individual encompasses spirit, soul, and body, please indicate if you request Dr. Wall or another staff member to pray for you prior to treatment.

☐ Yes ☐ No

DO NOT WRITE BELOW THIS LINE

Patient Accepted: Yes No Diagnosis: