Your Confidential Health Profile

Patient # __________ Date: ____________

Personal Information

Mr. Mrs. Ms. Miss. Dr. Name: ______________________________ Birth date: ________________

How do you wish to be addressed in the office? ______________________ Male Female _________

Address: ______________________________ City/Province/Postal Code: __________________________

Home Phone: _________________ Work Phone: _________________ Cell Phone: _________________

E-mail Address: ______________________________________ Occupation: ________________________

Single/Married/Divorced/Widowed/Common Law Partner's name: _______________________________

Children's Names & Ages: ____

Previous Chiropractor: ___________________ Last Visit: ______________ Concern: _________________

Medical Doctor: ______________________________ Phone Number: _____________________________

How did you hear about our office? ____

Reason for seeking care today & what effect is it having on your life:

Please mark an "X" where you believe your health is and an "O" where you would like it to be.

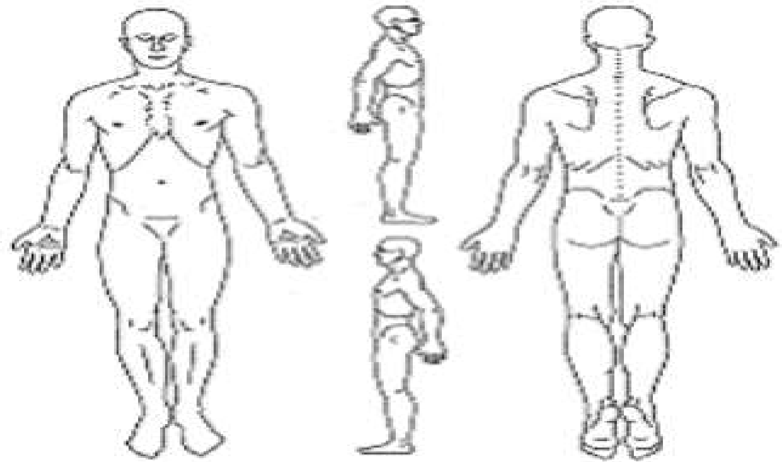
Current Health Profile

Health Concerns: list according to their severity:	Severity: 1 = mild 10 = worst	When did this episode start?	If you've had condition before, when?	Are symptoms constant or intermittent?
1. _________________________	______	______________	______________	__________________
2. _________________________	______	______________	______________	__________________
3. _________________________	______	______________	______________	__________________

Using the appropriate letters from the legend below, please mark any and all areas of concern:

Aching – AA
Burning – BB
Cramping – CC
Dull – DD
Muscle Spasm – MM
Numbness – NN
Pins & Needles - PN

Sharp – SP
Shooting – SH
Stabbing – SB
Stiffness – ST
Swelling – SW
Throbbing - TT



Does the pain travel/radiate anywhere? No Yes – describe: ____

Since the problem started, is it: the same getting better getting worse

What makes it worse? ____

What have you done that has helped you feel better? ____

What have you done for it that has been of NO help? ____

Is this interfering with your: work sleep exercise/sports hobbies positive mental attitude

Have you seen anyone else for this condition? If so, briefly explain when, treatment provided and results?
____

Have you had recent x-rays? No Yes Area of body: _______________________ When: _________________

Females only: Are you pregnant? Yes No First day of last period: _____________________________

Please circle if you have had any of the following, even if they are not related to your current condition:

Neck pain	Pins and needles in arm	Low back pain	Allergies
Headaches	Numbness in fingers	Pins and needles in the legs	Loss of smell
Sensitivity to light	Shoulder pain	Numbness in toes	Loss of taste
Dizziness	Middle back pain	Loss of balance	Sinus trouble
Fainting	Chest pain	Urinary problem	Fatigue
Trouble concentrating	Heartburn	Foot trouble	Cold sweats
Buzzing in ears	Difficulty breathing	Stomach problems	Hot flashes
Earache	Difficulty sleeping	Constipation	Depression
Nervousness	Cold hands	Diarrhea	Irritability
Tension	Cold feet	Ulcers	Mood swings
Women Only:	Menstrual pain	PMS	Irregular cycles

General Health Profile

What are your health objectives? ____

Are you healthier today than you were 5 years ago? ____

If so, what did you do to improve your health? ____

If not, why do you think your health declined? ____

Will you be healthier 5 years from now than you are today? ____

If so, what are you planning to do to improve your health? If not, what could you do to improve your health rather than have it decline? ____

Why do you want to improve your health? ____

Family Health Problems

Please list any health conditions or concerns that your immediate family may have:

Mother: ___________________________________ Father: ____

Brothers/Sisters: ____

Children: __________________________________ Spouse: ____

Lifestyle History

Briefly describe what you eat and drink in a typical day (don't forget to include water!): ____________________

____

How many hours of sleep do you get per day, on average? ____

Do you exercise? Yes No Off-and-On What do you do and how often? ______________________________

Overall stress level? Low Moderate High How do you manage your stress? ___________________________

What do you feel is your primary stress? ____

Please list your prescription medications: ____

____

Stress Profile

Chronic stress is the primary cause of the majority of health problems. Please review each of these common stresses and circle the appropriate response (C= current, P= past, N= never). Your answers will help enable us to determine which factors have contributed to your current concerns.

	Physical Stresses:				**Explanation**:
1.	Assisted delivery, or c-section	**P**	**C**	**N**	________________
2.	Accidents (auto, workplace, falls, sports, etc)	**P**	**C**	**N**	________________
3.	Surgeries	**P**	**C**	**N**	________________
4.	Sprains, strains, fractures	**P**	**C**	**N**	________________
5.	Poor posture (work, driving, etc)	**P**	**C**	**N**	________________
6.	Sleep position - stomach	**P**	**C**	**N**	________________
7.	Repetitive movements	**P**	**C**	**N**	________________
8.	Heavy lifting/bending	**P**	**C**	**N**	________________
9.	> 10 pounds overweight or from ‘ideal’ weight	**P**	**C**	**N**	________________
10.	Lack of exercise	**P**	**C**	**N**	________________
11.	Heavy purse/backpack/child	**P**	**C**	**N**	________________
12.	Sitting on wallet	**P**	**C**	**N**	________________
	Chemical Stresses:				
1.	Take prescription or OTC medications	**P**	**C**	**N**	________________
2.	Consume alcohol	**P**	**C**	**N**	________________
3.	Consume caffeine (coffee, tea, pop)	**P**	**C**	**N**	________________
4.	Smoke (# of years & # of packs/day)	**P**	**C**	**N**	________________
5.	Use artificial sweeteners (aspartame, sucralose)	**P**	**C**	**N**	________________
6.	Poor diet (fast food, white flour, white sugar)	**P**	**C**	**N**	________________
7.	Environmental pollution	**P**	**C**	**N**	________________
	Emotional Stresses:				
1.	Divorce of parents or spouse	**P**	**C**	**N**	________________
2.	Death of a loved one	**P**	**C**	**N**	________________
3.	Serious illness (self or loved one)	**P**	**C**	**N**	________________
4.	Financial concerns	**P**	**C**	**N**	________________
5.	Procrastination	**P**	**C**	**N**	________________
6.	Worry/fear/anxiety	**P**	**C**	**N**	________________
7.	Anger	**P**	**C**	**N**	________________
8.	Low self-esteem	**P**	**C**	**N**	________________

Signature: ______________________________ Parent/Guardian (if under 18): ______________________________