Your Confidential Health Profile

Personal Information **Date:_____**

Name:_____ Age: _____Birth Date (dd/mm/yyyy):_____

How do you wish to be addressed in our office? _____☐Male ☐Female

Address: _____

City/Province/Postal Code_____

Home Phone: _____ Work Phone: _____Mobile Phone:_____

E-mail Address: _____ Alberta Health Care #_____

Occupation: _____ Hobbies:_____

☐Single ☐Married ☐Divorced ☐Widowed Spouse or Partner's Name:_____

Children's Names & Ages: _____

Previous Chiropractor: _____ Last Visit: _____ Concern:_____

Who referred you to our office? _____ or ☐ internet ☐ phonebook ☐ location other _____

Is this visit related to a WCB or motor vehicle insurance claim? ☐ yes ☐ no If yes, what is the claim #: _____

Do you have extended health care benefits/private health insurance that cover chiropractic care? ☐ Yes ☐ No

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

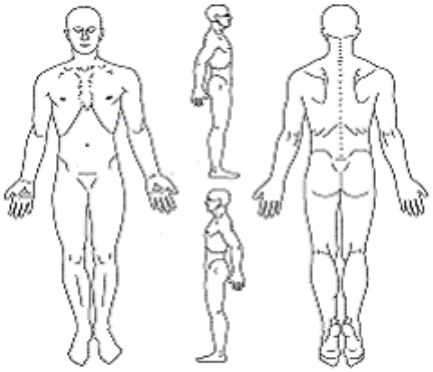
0-59 Very Challenged	60-69 Challenged	70-79 Transition	80-89 Good	90-100 Excellent

Current Health Profile

Health Concerns: List according to their severity:	**Severity:** 1= mild 10= worst	**When did this episode start?**	**If you've had this condition before, when?**	**Are symptoms constant or intermittent?**
1._____	___	_____	_____	_____
2._____	___	_____	_____	_____
3._____	___	_____	_____	_____
4._____	___	_____	_____	_____

Using the appropriate letter from the legend below, please mark any and all areas where you feel pain, numbness, spasm, tenderness or any other sensation that is unusual or abnormal:

Aching – AA
Burning – BB
Cramps – CC
Dull – DD
Muscle Spasm – MM
Numbness – NN
Pins & Needles – PN
Sharp - SP
Shooting - SH
Stabbing – SB
Stiffness – ST
Swelling - SW
Throbbing - TT



Please briefly describe your chief concern, including what you believe caused it to occur: _____
_____

_____

Does the pain travel/radiate anywhere? ☐No ☐Yes - please describe: _____

When did the problem first start? _____

Since the problem started, is it: ☐About 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 was of NO help?_____

Is this condition interfering with your: ☐Work ☐Sleep ☐Exercise ☐Hobbies ☐Positive Mental Attitude, ☐Other: _____

Other Health Care Professionals seen for this condition: _____

Treatment and Results:_____

_____

Were x-rays taken? ☐No ☐Yes Area of body:_____ Date: _____

General Health Profile

What are your health objectives?_____

Name of the last doctor who put you on a health development program? _____

Were you able to stay on the program? _____ How long?_____

What were your results? _____Were they permanent?_____

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 continue to decline? _____

Why do you want to improve your health? _____

_____

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

☐Neck pain	☐Pins and needles in arms	☐Low Back Pain	☐Allergies
☐ Headaches	☐Numbness in fingers	☐Pins and needles in legs	☐Asthma
☐ Migraine Headaches	☐Shoulder Pain	☐Numbness in toes	☐Loss of taste
☐Dizziness	☐Mid back Pain	☐Loss of balance	☐Sinus Trouble
☐Fainting	☐Chest Pain	☐Urinary Problem	☐Fatigue
☐Loss of Concentration	☐Heartburn	☐Kidney Problem	☐Cold Sweats
☐Ear Problems	☐Difficulty Breathing	☐Stomach Upset	☐Hot Flashes
☐ Vision Problems	☐Sleeping problems	☐Constipation	☐Depression
☐Nervousness	☐Cold Hands	☐Diarrhea	☐Irritability
☐Tension	☐Cold Feet	☐Irritable Bowel	☐Mood Swings

Women Only: ☐Menstrual Pain ☐PMS Are you pregnant? ☐Yes ☐No

Family Health Profile

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

Mother: _____Father:_____

Brothers/Sisters:_____

Children:_____ Spouse: _____

Stress Profile

Chronic stress is the cause of the majority of health problems. Please review each of these common stresses and circle when you experienced it in your life. Use P for Past and C for Current. Your answers will help enable us to determine which factors have contributed to your present health concerns.

Physical Stress:

(P= past, C= current) **Explanation:**

1. Forceps, suction extraction, or caesarean delivery P C _____
2. Accidents (auto, work related, falls or other) P C_____
3. Surgical operations P C_____
4. Strains, sprains, and/or broken bones P C_____
5. Poor posture (excessive computer work, sitting, driving) P C_____
6. Poor sleeping habits P C_____
7. Repetitive movements P C_____
8. Sports injuries P C_____
9. Heavy lifting and/or bending P C_____
10. Overweight P C_____
11. Lack of exercise P C_____

Chemical Stress:

1. Take prescription or over-the-counter medication P C _____
2. Consume alcohol P C_____
3. Consume caffeine (coffee, tea, pop) P C_____
4. Use tobacco products P C_____
5. Use artificial sweeteners (aspartame, sucralose) P C_____
6. Poor diet (fast food, white flour, white sugar) P C_____
7. Environmental pollution P C_____
8. Overweight P C_____

Emotional Stress:

1. Divorce of parents or spouse P C _____
2. Death of a loved one P C_____
3. Serious illness (self or a loved one) P C_____
4. Financial concerns P C_____
5. Procrastination P C_____
6. Worry and/or fear P C_____
7. Work environment P C_____
8. Relationships/Family P C_____
9. Anger by you or at you P C_____
10. Low self-esteem P C_____

Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke rather, recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.
I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.
I intend this consent to apply to all my present and future chiropractic care.

PLEASE DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

Dated this_____ day of _____. 20_____.

_____ _____

Patient Signature (Legal Guardian) Signature of Chiropractor

Name:_____

(please print)