Adult Health Profile

Date: _____

Patient's Full Name: _____

Patient's Date of Birth: _____ Sex: M F
Day/Month/Year (circle one)

Full Address:

_____
Street # Street Name Unit # City Province Postal code

Telephone:

_____
Primary: Please circle (home) (work) (cell) Secondary: Please circle (home) (work) (cell)

_____
Email Address

How did you hear about our clinic? _____

In Case of Emergency:

Contact: _____ _____ (___) _____
Full Name Relation Telephone

FOR OFFICE USE:

Date	Presenting/Major Complaints
A	
B	

Main Health Concerns:

1. Do you have any current symptoms or health concerns that brought you to our office? Please describe the most important one to you. (When it began, is it improving or getting worse, how it is impacting your life, any previous treatment)

   _____

   _____

2. Any other concerns that are impacting your life?

   _____

   _____

General Physical Stress/Trauma:

Primary Complaints and Pain Diagram:

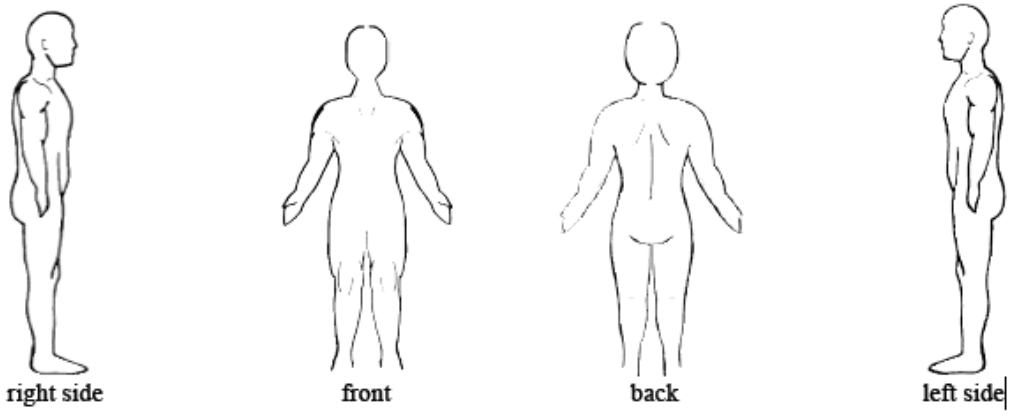
Please mark an "X" on the line to indicate the severity of your condition:

No symptoms
Does not interfere with activities

Extreme symptoms
Disabling

☺----------😐----------☹

Please mark any areas of concern on the diagrams below. N – numbness P- pins & needles B- burning A- aching S-stabbing Indicate any other problems as best you can.



right side front back left side

Please provide the trauma/injury, level of trauma (mild/moderate/severe), dates, and any other important details of the following:

Vehicle accidents _____

Work injuries _____

Falls _____

Sports injuries _____

Other _____

On a typical day I (check all that may apply):

□ Sit □ Stand □ Drive □ Computer/desk work □ Physical labour

Health/Illness/Trauma/Medical Treatment:

Any current medical issues? (date of your last medical examination):

_____

Have you ever been hospitalized or had surgery? □ Yes □ No

Reason: _____

Have you previously had chiropractic care? □ Yes □ No Reason: _____

Have you ever had physiotherapy? □ Yes □ No Injury treated: _____

Do you consult with a Naturopathic Doctor? □ Yes □ No

Current care addressing: _____

Do we have your permission to send reports to your medical/health professionals? □ Yes □ No

Please list names of pertinent medical and naturopathic care providers:

1. _____
2. _____

Sports and Leisure:

I exercise: □ Daily □ Weekly □ Monthly □ Never

Type of activity: _____

Are you participating in a sport currently or in the past?

□ Yes □ No Describe: _____

Have you experienced any injuries while participating in these activities?

Describe: _____

Chemical and Nutritional Stressors:

Are you taking any medications currently (prescription or over the counter)?

□ Yes □ No Please list:_____

Have you taken any in the past? Please list: _____

Please list any herbs/supplements or natural remedies you take regularly: _____

_____

Do you smoke currently or have you in the past? □ Yes □ No _____

Do you drink coffee or tea regularly? □ Yes □ No (amount/day)_____

Do you regularly consume diet beverages? □ Yes □ No (amount/day) _____

Do you consume processed foods or refined sugar daily/weekly? □ Yes □ No

Do you regularly consume alcohol? (amount/week) _____

Do you regularly take recreational drugs? _____

Emotional/Mental Stressors:

Pain that is physical can be related to, and brought on over time with emotional experiences. The following helps us determine levels of stress that can be impacting your physical health. Please indicate the level of stress you have or currently experience (mild/moderate/severe) and how it impacts you.

Stress from an illness _____

Financial stress _____

Marital stress _____

Work stress _____

Familial stress _____

Past stress _____

Other _____

How would you grade your emotional/mental health?

□ Excellent □ Good □ Fair

and

□ Getting better □ Getting worse

Family History:

Parents' ages: Mother _____ Father _____

Do you consider them to be in good health? _____

Circle any that apply to your parents, siblings or children and explain.

Diabetes _____ *High blood pressure* _____

Stroke _____ *Heart disease* _____

Cancer _____ *Lung disease* _____

Seizures _____ *Tremors* _____

Neurological _____ *Arthritis* _____

Scoliosis _____ *ADD/ADHD*_____

Other _____

Your Specific Needs and Goals:

What are your objectives in consulting our office? _____

_____

Is there anything else that may help us to understand you, your history, or your needs, which have not been discussed on this health profile?

_____

_____

Patient Name (print)_____ **Date** _____

Patient signature _____

Please circle all the symptoms that you have experienced in the last 6 months and underline symptoms that have occurred in the past that were significant in your health history.

HEAD:
Headache
Frequency __x/week or month
Back of head
Forehead
Temples
Migraine
Light bothers eyes
Blurred vision
Loss/change in vision
Loss/change in taste
Loss/change in hearing
Loss/change in balance
Dizziness
Light-headedness
Pain in ears or Ringing in ears

NECK:
Neck pain
Ache
Stiff
Sharp
Neck pain with movement
Grinding or popping sounds

MID-BACK:
Mid-back pain
Ache
Stiff
Sharp
Tension across shoulders
Pain between shoulder blades
Muscle spasms

CHEST:
Chest pain
Shortness of breath
Rib pain

HAND and ARM:
Pain in arm
RIGHT or LEFT
Tendonitis at elbow
RIGHT or LEFT
Pain into hands/fingers
RIGHT or LEFT
Pins and Needles sensation
RIGHT or LEFT
Numbness
RIGHT or LEFT
Hands cold
Loss of grip strength
Sore/swollen joints in fingers
Arthritis in fingers

LOW BACK:
Lower back pain
RIGHT or LEFT or *CENTRE*
Ache
Stiff
Sharp
Muscle Spasms
'Pinched nerve' sensation

Low back pain worse with:
Lifting
Stooping/bending
Standing
Sitting (chair or driving)
Lying down
Walking
Coughing

Low back pain better with:
Sitting
Standing
Bending
Lying down
Walking

LOWER BODY & LEG PAIN:
Pain into buttock - legs
RIGHT or LEFT
Pain into leg and foot
RIGHT or LEFT
Pins and needles in legs
Numbness in legs/feet
Pain into hips
RIGHT or LEFT
Swelling into legs or feet
Leg cramps
Foot pain
RIGHT or LEFT

DIGESTIVE/ABDOMEN:
Nausea
Bloating/Gas
Constipation
Diarrhea
Irritable bowels
Chron's
Food sensitivities

GENERAL HEALTH:
Nervousness
Anxious
Depressed feelings
Fatigue/Run down feeling
Trouble concentrating
Sleep challenges
Loss of weight __lbs
Gain of weight __lbs
Heart palpitations
Allergies
_____
Sensitivities
_____