

CONFIDENTIAL CASE HISTORY

WELCOME TO DISCOVER CHIROPRACTIC FAMILY WELLNESS CENTRE

THE IMPORTANCE OF THIS FORM AND YOUR PRIVACY

DATE: _____

This information will be used to assist the doctor in making the best choices for your examination AND for deciding how chiropractic care can best help you. Please answer all questions and when there are “none” or “non-applicable” please indicate. The information collected **will be kept confidential** and will only be used for clinical purposes. It **WILL NOT** be shared with anyone else without YOUR express permission.

Care Card PHN# _____ Last Name _____ First Name _____

Birth date (M/D/Y) _____ Age _____ Female _____ Male _____ Occupation _____

Address _____ City _____ Postal Code _____

Email Address _____ Do you consent to us sending you information by email? Y N

Home Phone _____ Work Phone _____ Name of Spouse _____

Names/ages of children _____

Name and number of Emergency Contact _____

How did you find out about our office? _____

If you were referred to our office, whom may we thank? _____

STOP!! PLEASE READ!!! The purpose of today’s visit is to provide a detailed and complete physical examination. **ONLY in EXCEPTIONAL circumstances will any adjustments be performed** prior to your file being carefully analyzed and the findings presented (usually on your next visit). This approach is consistent with any significant health-related procedure. You will find that the two things we never compromise are YOUR HEALTH and OUR REPUTATION.

The fee for today’s examination is \$60. If you strongly desire an adjustment and the doctor determines that is acceptable to do so, the regular adjustment fee of \$45 will be added to the examination fee. **(Total fee = \$105.)**

PLEASE INITIAL HERE indicating that you have read and understand this section: _____

CURRENT AND PAST BODY SIGNALS INDICATING UNDERLYING DYSFUNCTION

Please indicate which of the following body signals apply (use “C” for current and “P” for previous):

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pins/Needles in Arms/Leg |
| <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Stress | <input type="checkbox"/> Muscle Tension | <input type="checkbox"/> Overall Joint Pain/Stiffness |
| <input type="checkbox"/> Difficulty Walking/Sitting | <input type="checkbox"/> Difficulty Driving | <input type="checkbox"/> Difficulty Working | <input type="checkbox"/> Difficulty Lifting/Bending |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Loss of Balance/Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Coordination |
| <input type="checkbox"/> Frequent Colds/Flu | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Diarrhea/Constipation |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Moody/Irritable | <input type="checkbox"/> Lack of Concentration |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Menopausal Difficulties |
| <input type="checkbox"/> Fertility Dysfunction | <input type="checkbox"/> Prostate Dysfunction | <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Menstrual Difficulties |

Are any of your friends or family suffering from any of these dangerous body signals? Yes No

If so, who? _____

Have you been under chiropractic care before? Yes No What was the date of your last visit? _____

Was your experience positive, negative or neutral? _____ Why? _____

Do you wear orthotics or special shoe inserts? Yes No How old are they? _____

REASON FOR YOUR VISIT

Is this a WCB Case? (work related injury) Yes (see form WCB) No
Is this an ICBC Case? (motor vehicle accident) Yes (see form ICBC) No

What brought you into our office/What is your main concern? _____

When did the first symptom of this underlying dysfunction arise? _____

Have you had this problem before? Yes No How long ago? _____

Is there a specific event that caused your current concern? (describe) _____

Are your symptoms: Constant Intermittent Daily

Do your symptoms stay in the same place or do they radiate? If so, where? _____

What is the intensity of your pain/symptoms on a scale of 1 to 10? (10 being the worse) _____

Describe the character of your pain/symptoms (dull, achy, sharp, throbbing, numbness etc) _____

What aggravates your symptoms? _____

What relieves your symptoms? _____

Anything associated with your pain/symptoms? (wake you at night, problem urinating, fever etc) _____

Does this problem interfere with: Work Sleep Daily routine Moods

Are your problems: getting worse getting better staying the same

Other Doctors/Therapists that have treated this condition _____

What treatments were given? _____

Were X-rays taken? Y N If yes, when? _____

Do you have any other concerns? _____

Have you ever had surgery? Yes No

Describe _____

Have you been diagnosed with any medical conditions? Yes No

Describe _____

Are you now using or have you ever used prescription drugs? Yes No

Describe **PAST** _____

CURRENT _____

LIFESTYLE ASSESSMENT

We are all innately programmed for wellness. In order to express optimal health one needs only to supply the necessary quality ingredients (purity) in the right amounts (sufficiency). Interferences to wellness can be created by not having enough of something essential (deficiency) or too much of something harmful (toxicity). We have created this questionnaire to assess your levels of deficiency and toxicity in the areas of nutrition, movement, and thought. Please answer honestly and in detail so that we may best guide you to your most vibrant level of health!

EATING WELL "You are what you eat"

Deficiency:

Whole, natural foods - Do you eat 8-10 servings of fruits and vegetables/day? Yes No

If not how many? _____ Fruits _____ Vegetables

Omega-3's - Is your intake of essential fatty acids adequate? Yes No

What is the source? _____ Quantity? _____

Pure water – are you drinking 30ml/kg (½ oz of per pound) of body weight/day? Yes No

If not, how much water do you drink? _____

Toxicity:

Do you drink alcohol? If so, how many drinks of alcohol do you intake per week? _____ Yes No

Do you smoke cigarettes? If so, how many packs/week? _____ For how many years? _____ Yes No

Are you now using or have you ever used recreational drugs? Yes No

Do you eat/crave junk food? (Please circle all that apply) Fast food, processed food, sweets Yes No

MOVING WELL "Movement is life, and Chiropractic delivers!"

Deficiency:

Do you follow a regular aerobic exercise program (At least 30 minutes/day)? Yes No

Do you perform postural exercises for your spine daily? Yes No

Do you follow a strength training program, 2-3 X/week involving all major muscle groups? Yes No

Toxicity:

Have you ever been involved in a car accident? If so when? _____ Yes No

Describe _____

How many hours, on average, do you sit daily? _____ At a computer? Yes No

Have you had any major injuries (sports, etc.)? If so, when? _____ Yes No

Describe _____

THINKING WELL "Our thoughts create our world"

Deficiency:

Do you have daily stress reduction strategies? Yes No

Do you have a strong support network of friends and family? Yes No

Toxicity:

Do you engage in negative self talk (self-critical, perfectionist tendencies)? Yes No

Do you have chronic stress in your life? Yes No

Rate the level of stress in your work life. Low Moderate High Severe

Rate the level of stress in your personal life. Low Moderate High Severe

IMPORTANT!!

Please tell us what you MOST want out of your experience here - what is/are your goal(s)?

How will we know that your goals are being met?