Comprehensive Health Profile

Date:____/____/____

Last Name:_____ First Name:_____

Date of Birth: DD / MM / YY AGE_____ Referred By:_____

MHSC#(6 digit)_____ PHIN#_____ Insurance: YES □ NO □

Address:_____ City/Prov.:_____ Postal Code:_____

Home Phone:_____ Business Phone:_____ Cell:_____

Email:_____ Occupation:_____

Marital Status: S M D W Number of Children:____ Current Weight:_____ Current Height_____

GENERAL HISTORY

Have you ever been to a chiropractor before? YES □ NO □ Were you pleased with your care YES □ NO □

What is your primary reason and/or health concern for coming today:_____

_____

The scale below is used for the following section.

0 – does NOT affect me **1 –** affects me slightly **2 –** affects me moderately **3 –** drastically affects me

Please circle the level, which the above health concern affects the following aspects in your life.

WORK	0 1 2 3	Eating	0 1 2 3	Rest/Sleep	0 1 2 3
Social Life	0 1 2 3	Walking	0 1 2 3	Exercise	0 1 2 3
Recreation	0 1 2 3	Love Life	0 1 2 3	Sleep	0 1 2 3

Concern about Particular Symptom 0 1 2 3 Concern about Health/Well-Being 0 1 2 3

Have you sought treatment for the above health concern YES □ NO □

If yes, please answer the following questions:

Specify the types of treatments_____

What was explained?_____

Did you see improvement of the health concern after treatments? YES □ NO □

What was different about YOU after the treatments?_____

Has your health concern persisted after these treatments? YES □ NO □

Why do you think this condition continues to occur?_____

Do you believe this to be the sole cause? YES □ NO □

If no, what else is involved?_____

How do you feel about your current health concern? (Choose ONE of the below that best describes how you feel)

□ I feel helpless; nothing works
□ I don't like what I am feeling and I hope you can fix it
□ I feel this is a pattern that has happened to me before and it is back again
□ I feel there is a message my body is giving me
□ I am looking for something to help me enhance my quality of life and further enhance my wellness

STRESS HISTORY

The scale below is used for the following section.

0 – No awareness of any stress 1 – slight stress 2 – Moderate Stress 3 – Extreme Stress

PHYSICAL STRESS

OVERALL Physical Stress

Includes falls, accidents, injuries, repeated postural stress, impacts, difficult birth, physical abuse, loss of consciousness, broken/fractured bones, etc.

BIRTH HISTORY

Did your mother have a difficult pregnancy with you? YES □ NO □

Was the birth traumatic YES □ NO □ If yes, were you incubated YES □ NO □

Was the birth… *check any of the following*

□ Drug Induced □ Forceps or Suction □ Prolonged □ C Section □ Breech

□ Cord around the neck □ Natural □ Other:_____

GENERAL PHYSICAL TRAUMA

Have you ever been knocked unconscious? YES □ NO □ How/When?_____

Have you broken any bones? YES □ NO □ Please Specify_____

Have you had any impacts/falls that you feel may have injured your spine? YES □ NO □

If yes, how/when?_____

Have you served in the military? YES □ NO □ If yes, were you involved combat? YES □ NO □

On average, how many hours per day do you participate in the follow? Sitting_____ Standing_____

Desk Work____ Phone Work_____ Computer Work_____ Driving_____ Lifting/Heavy Objects_____

Manual Labour____ Stooping/Bending/Kneeling_____

SPORTS/LEISURE

Were you or are you active in any sports? YES □ NO □ Which one(s)?_____

Have you been injured during activities? YES □ NO □ How?_____

ACCIDENTS

Have you ever been involved in a vehicle accident (bus, bicycle, airplane, car) or near collision? YES □ NO □

Please specify_____

_____

MEDICAL

Have you ever been hospitalized? YES □ NO □ If yes, what was the reason?_____

Have you had surgery? YES □ NO □ Please specify?_____

Have you had any of the follow:

□ Spinal Tap □ Spinal Injections □ Traction □ Neck Collar □ Spinal Brace □Heel Lift

□ X-Rays □ Corrective Shoes □ Transfusion □ Acupuncture □ Physiotherapy □ Chemotherapy

□ Extensive Diagnostic X-Rays □ Body Part in Cast or Immobilized

CHEMICAL HISTORY

OVERALL Chemical Stress 0 1 2 3

Includes prescription drugs, drugs taken need from surgery, over-the-counter medications, smoke, alcohol, caffeine, fumes, food additives, etc.)

GENERAL CHEMICAL TRAUMA

Are you currently taking any drugs (prescription/over-the-counter)? Please list them and reasons for taking them:

PRESCRIPTION REASON

_____ _____

_____ _____

Have you ever had a history of abuse or heavy use of….□ Alcohol □ Smoking

Have you ever been exposed to chemical, fume, dust, powder, smoke for prolonged periods? □ YES □ NO

Please specify the number per day for the following products:

Alcohol _____ Coffee _____ Tobacco _____ Artificial Sweeteners _____

Soda _____ Refined Sugar (candy/pastries/day) _____

EMOTIONAL HISTORY

OVERALL Emotional/Mental Stress 0 1 2 3

Includes: loss of loved ones, rapid change in life situations, abuse, move of home/school, legal concerns, financial concerns, divorce, relationships, etc).

With each of the following POTENTIAL STRESS situations, please indicate the severity for past or current

Potential Stress	**PAST**			**CURRENT**		
Childhood Stress	MILD □	MODERATE □	EXTREME□	MILD □	MODERATE □	EXTREME□
School Stress	MILD □	MODERATE □	EXTREME□	MILD □	MODERATE □	EXTREME□
Family Stress	MILD □	MODERATE □	EXTREME□	MILD □	MODERATE □	EXTREME□
Personal Relationships	MILD □	MODERATE □	EXTREME□	MILD □	MODERATE □	EXTREME□
Stress of being Sick	MILD □	MODERATE □	EXTREME□	MILD □	MODERATE □	EXTREME□
Work Stress	MILD □	MODERATE □	EXTREME□	MILD □	MODERATE □	EXTREME□
Stress of Commuting	MILD □	MODERATE □	EXTREME□	MILD □	MODERATE □	EXTREME□
Loss of Loved One	MILD □	MODERATE □	EXTREME□	MILD □	MODERATE □	EXTREME□
Change in Lifestyle	MILD □	MODERATE □	EXTREME□	MILD □	MODERATE □	EXTREME□
Change in Vocation	MILD □	MODERATE □	EXTREME□	MILD □	MODERATE □	EXTREME□
Abuse (verbal, physical, emotional, sexual)	MILD □	MODERATE □	EXTREME□	MILD □	MODERATE □	EXTREME□

OUR SERVICE

Our service to you is very important, please let us know what you are hoping to receive from this care.

_____

_____

_____

_____

As our office grows because of client's referrals, we would like to know how we can get a referral from you?

_____

_____

_____

_____