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A NATURAL PATH TO HEALTH
LIVE WELL

Your Wellness Profile & History

Date: _____

Name: _____ **DOB (D/M/Y):** _____ **Age:** _____ **Male** **Female**

Address: _____ **City:** _____ **Province:** ____ **Postal Code:** _____

Home : ( )_____ **Work:** ( )_____ **Cell:** ( )_____

Status: Single Married Divorced Widowed **# of Children:** _____ **Occupation:** _____

Who may we thank for referring you to us? _____ **Email Address:** _____

Who is your primary healthcare provider? _____ **Phone number:** ( )_____

Would you like appointment reminders sent via Email? **Yes** ____

Would you like statements sent to you automatically via Email? **Yes** ____

YOUR HEALTH PROFILE

Please briefly describe what brings you into our office today _____

_____

Severity of symptoms - scale 1-10 (1 being mild) _____ Symptoms are: Constant ___ Intermittent____

When and how did this start? _____

Since the problem started it is ___the same ___getting better ___ getting worse

What makes the problem worse?_____

What, if anything, makes the problem feel better?_____

Who have you seen for this condition? ___Chiropractor ___MD ___Physio ___ Other _____

Name(s) and approximately when _____

What was the diagnosis and treatment provided _____

Over the past 90 days has pain or dysfunction limited your ability to: ___ lift heavy objects ___ stand
___ sit ___ walk ___ sleep ___ drive ___ socialize ___ exercise/sports

GENERAL HISTORY

Please list all current and past significant health conditions, diseases and injuries, as well as past surgeries

_____

_____

Please list any medications you are taking, and why. _____

_____

Have you or a close relative ever been diagnosed with cancer? ___Yes Who? _____ Type_____

For women: Are you currently pregnant? ___Yes ___No

Do you have any allergies? ___Yes ___No If yes list _____

Do/Did you smoke? ___Yes ___No How many hours a day do you sit? _____

Are you aware of any complications occurring during your birth? (antibiotics, forceps, vacuum, c-section , cord)

_____

As a child did you take medication for an extended period (incl. cortisone creams) ?_____

Have you been diagnosed with scoliosis? _____ Do/did you wear orthotics?____ A heel lift? _____

Please check all appropriate symptoms even if they do not seem related to your current problem

Recent	Past		Recent	Past		Recent	Past	
❑	❑	Headaches/Migraines	❑	❑	Irritability	❑	❑	Depression
❑	❑	Pins & needles in arms	❑	❑	Cold hands/feet	❑	❑	Fertility issues
❑	❑	Pins & needles in legs	❑	❑	Repeated ear infection	❑	❑	Menstrual pain
❑	❑	Dizziness	❑	❑	Fever	❑	❑	Menstrual irregularity
❑	❑	Numbness in fingers	❑	❑	Urinary problem	❑	❑	Cold sweats
❑	❑	Fatigue	❑	❑	Fainting	❑	❑	Mood swings
❑	❑	Sleeping problems	❑	❑	Eyes bothered by light	❑	❑	Loss of smell/taste
❑	❑	Tension	❑	❑	Stomach upset/Nausea	❑	❑	General stiffness
❑	❑	Ulcers	❑	❑	Diarrhea/Constipation	❑	❑	Back pain
❑	❑	Buzzing/Ringing in ears	❑	❑	Difficulty concentrating	❑	❑	Neck pain
❑	❑	Numbness in toes	❑	❑	Reflux/Heartburn	❑	❑	Stiff neck

An important component of care is regular reassessment, please rate the following:

Your overall quality of life	low	1	2	3	4	5	6	7	8	9	10	high
Your mood	low	1	2	3	4	5	6	7	8	9	10	high
Your energy	low	1	2	3	4	5	6	7	8	9	10	high
Your ability to move	low	1	2	3	4	5	6	7	8	9	10	high
Your ability to do household activities	low	1	2	3	4	5	6	7	8	9	10	high
Your ability to do recreational activities	low	1	2	3	4	5	6	7	8	9	10	high

YOUR STRESS PROFILE

1. Physical Stresses ***please fill out!***

Have you had work related injuries? Yes ___ Briefly explain: _____
Have you had sports related injuries? Yes___ Briefly explain: _____
Have you had slips, falls or auto accidents? Yes ___ Briefly explain: _____

2. Emotional Psychological Stresses On a scale of 1 (none) - 10 (extreme) ***please fill out!***

__/10 Occupational /School stresses: _____
__/10 Family/Relationship stresses: _____
__/10 Other stresses (eg. financial): _____

3. Nutritional Chemical Stresses On a scale of 1 (poor) - 10 (excellent) ***please fill out!***

Water ____/10, Proteins ____/10, Healthy Fats ____/10, Fruits/Vegetables____/10

Is your diet high in: Sugar ___ Unhealthy snacks ___ Soda ___ Processed foods ___

Which of the following Essential Nutrients do you take regularly Omega 3 ___ Vit D ___ Probiotics___
List other supplements you take regularly _____

Rate the following: Exercise ___/10 Sleep___/10 Positive Attitude ___/10 Wellness lifestyle___/10

Please let us know if there are any health related issues that concern you, aside from the main problem that you are coming here for _____

_____

_____

Consent To Care

Our Chiropractic practitioners generally employ “tonal” instrument assisted techniques that do not involve rotational adjustment of the neck. These techniques allow the Chiropractic care provided to you to have a profound effect on your spine and nerve system through gentle taps without the use of forceful movements.

In general, Chiropractic care is safer than taking anti-inflammatories, pain killers, and virtually any other medication. There has been some concern about injury to the vertebral artery with extreme rotational movements of the neck being associated with stroke on rare occasion. Firstly, research and scientific evidence have not established a cause and effect relationship between Chiropractic adjustments and the occurrence of stroke. Secondly, our practitioners employ non-manipulative techniques, except in the event that it is agreed upon by the patient and doctor to use other adjusting techniques, because it makes clinical sense to do so. As with any manual therapy there is always the possibility of soft tissue strain or irritation, minor discomfort and short term aggravation of symptoms as nerve function improves, functionality changes and tissues balance.

Chiropractors do not diagnose disease or disease processes. We focus on detecting, locating and correcting Vertebral Subluxation (spinal neural malfunction) in as gentle a manner as possible, to enable your body to function and heal to the best of its’ ability.

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 a professional and complete spinal-neural examination, including Insight scans that the Doctor deems necessary and to Chiropractic care offered or recommended to me by Dr. Weitz or Dr. Merzel including spinal adjustment. I intend this consent to apply to all my present and future care.

I will inform the Doctor of any changes in my health status that occur between visits (eg. pregnancy)

I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date. <u>Please note many of our patients prefer to leave a credit card number on file with us which we bill according to your express instructions</u>.

Dated this_____ day of _____, 20___

_____ _____ (Verified by: _____)

Patient Signature Patient Name (please print)

For patients under 16 years of age:

On behalf of_____, I have read the above & I hereby authorize Dr. Weitz, or such substitute as he may designate, to perform a complete spinal-neural examination and I consent to Chiropractic care recommended by Dr. Weitz, including spinal adjustment.
I intend this consent to apply to all present and future care.

Dated this_____ day of _____, 20___

_____ _____

Guardian Signature Guardian Name (please print)

(Verified by: _____ _____)