

WHALE FAMILY CHIROPRACTIC

Dr. Robin Whale & Dr. Caroline Taylor

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GENERAL INFORMATION

Name:

DOB (D/M/Y):

Age:

Address:

Cell Phone:

Alternate Phone:

Email Address:

Can we text and/or email you? Yes No

Occupation:

Employer:

Work Tasks (sitting, lifting, standing):

Do you have children? Yes No

If comfortable, please provide their names and ages below:

Emergency Contact Name:

Contact Number:

Relationship to you (parent, spouse):

Who may we thank for referring you to this office?

HEALTH PROFILE

What brings you to our office today? _____

When and how did the problem occur? _____

If condition has occurred before, when? _____

Symptoms & Pattern:

Sharp

Dull

Achy

Pins & Needles

Numb

Constant

Intermittent

Occasional

Cyclical

Provide a number between 1 and 10 that best describes the current severity of your discomfort: _____ (1 = MILD, 10 = SEVERE)

What make your symptoms feel worse? _____

What makes your symptoms feel better? _____

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Have you seen any other health care providers for your issue(s)? If so, what form(s) of treatment (e.g. acupuncture, massage, physiotherapy, medication) and what were the results?

Are there other things you do personally to reduce discomfort or improve your general health (yoga, walking, stretching, sports)?

How is this condition affecting your ability to work and/or enjoy your free time?

What would you be doing if you felt your best again?

Who do you have as a personal support system for your health/goals, etc. (e.g. spouse, parent, friend)?

Have you ever been adjusted by a chiropractor before? Yes No If so, how often and for what length of time?

Results of chiropractic care (if applicable):

Have you had spinal x-rays taken within the last five years? Yes No If so, can a copy be provided to us? Yes No

Are there any other health concerns you would also like to discuss at this time?

What level of care are you seeking at this time?

- "Band-aid" Fix (just get rid of current symptoms)
- Corrective Care (aim to fix cause of symptoms)
- Wellness Care (improve overall health and vitality)

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SYSTEM CHALLENGES

Has your body communicated any of the following symptoms?

While it may seem unrelated to the purpose of your visit, this helps us with your overall assessment and care plan.

Check the symptoms *affecting you now*, and add letter "R" or "O" next to those that have been **Repeated** or **Ongoing**:

Nervous System

- Nervous ____
- Numbness ____
- Paralysis ____
- Dizziness ____
- Forgetfulness ____
- Confusion/Depression ____
- Fainting ____
- Convulsions ____
- Cold/Tingling Extremities ____
- Stress ____

Musculo-Skeletal

- Low Back Pain ____
- Pain Between Shoulders ____
- Neck Pain ____
- Leg Pain ____
- Arm Pain ____
- Joint Pain/Stiffness ____
- Walking Problems ____
- Difficult Chewing/Clicking Jaw ____
- General Stiffness ____

General

- Fatigue ____
- Allergies ____
- Loss of Sleep ____
- Fever ____
- Headaches/Migraines ____

Cardio-Vascular/Respiratory

- Chest Pain ____
- Stroke ____
- Blood Pressure Problems ____
- Irregular Heartbeat ____
- Heart Problems ____
- Lung Problems/Congestion ____
- Varicose Veins ____
- Ankle Swelling ____

EENT

- Vision Problems ____
- Dental Problems ____
- Sore Throat ____
- Ear Aches ____
- Hearing Difficulty ____
- Stuffed Nose ____

Gastro-Intestinal

- Poor/Excessive Appetite ____
- Excessive Thirst ____
- Frequent Nausea ____
- Vomiting ____
- Diarrhea or Constipation ____
- Heartburn ____
- Hemorrhoids ____
- Liver Problems ____
- Gall Bladder Problems ____
- Weight Trouble ____
- Abdominal Cramps/Bloat ____

FEMALES ONLY

Are you pregnant, or could you be?

- Yes
- No

When was your last period?

- Menstrual Irregularity
- Menstrual Cramping
- Vaginal Pain / Infections
- Breast Pain / Lumps

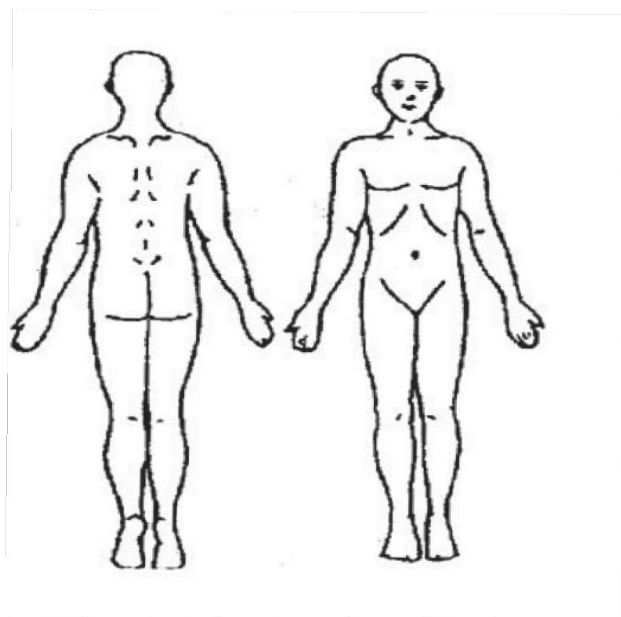
MALES ONLY

- Prostate Problems
- Sexual Dysfunction

Please indicate on the diagram to the right any area(s) of discomfort, including radiation of pain or numbness.

Circle = Aching
S = Sharp Pain
T = Tingling
R = Radiating
N = Numbness

NOTE: When using auto-fill PDF version of this form, this diagram will need to be completed by hand on the printed hard copy.



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STRESS PROFILE

The state of your body and health are a result of all that has happened to you up until this point in life. You face many physical, chemical and emotional stresses which your nervous system needs to integrate and adapt to. There are times when your body and nervous system have been overwhelmed by these stresses and your ability to thrive has been compromised. Details of your stressors throughout life will enhance our understanding of your current state of health.

** Please provide details of Early Life and/or Adult (current) stressors, as applicable **

PHYSICAL STRESSORS

Please describe the most significant physical stresses you have faced, starting in your childhood. These types of stresses can be short-term and traumatic, or longer-term and repetitive. For both time frames (early life and adult), list any serious accidents/falls/injuries, broken bones, surgeries, car/vehicle accidents, etc.

Early life examples: Difficult/C-section birth, significant or repeated falls as a child (from a height, down stairs, in sports), carrying a heavy backpack, sedentary lifestyle, extensive sitting (over 2 hours/day outside of school), slouching, demanding sports schedule.

Adult life examples: Commuting significant distance to work and/or a seated job, work injuries, job with very repetitive/one sided tasks, poor sleep, poor posture, lack of regular exercise, TV or technology usage for more than 2 hrs/day.

CHEMICAL STRESSORS

Please describe the chemical stressors your body has encountered.

Early life examples: Poor diet (didn't eat all food groups), high sugar/pop consumption, second-hand smoke, over-the-counter or prescription medication (inhalers, antibiotics, pain medication), low water consumption, alcohol and/or drug use at a young age.

Adult life examples: Smoking/vaping, poor diet (processed foods, no veggies, etc.), not drinking enough water, high-sugar use, artificial sweeteners (i.e. diet pop), excessive caffeine, regular alcohol/drug use, workplace exposure to chemicals/toxins.

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STRESS PROFILE (Continued)

Please list your medications and what they are for:

Please list any vitamins/supplements you currently take:

EMOTIONAL/MENTAL STRESSORS

We face many emotionally stressful events in our lives, please list them below knowing they will be met without judgement.

Early life examples: Difficult/unstable home environment, divorce, emotional or other abuse, not allowed to express emotions, bullying, anxiousness/shyness, learning or school-related challenges.

Adult life examples: Marital issues/divorce, financial stresses, loneliness, depression/anxiety, perfectionist/control issues, illness (self or someone close to you), grief/loss, highly demanding career, parenting challenges, etc.

FAMILY HEALTH HISTORY

List any serious health conditions known in your immediate family history (parent, sibling, grand parent). For example: cancer, diabetes, heart disease, migraines, scoliosis, etc.

GOALS FOR OPTIMAL HEALTH

What are a few specific goals you could incorporate into your life at this time to improve your health? (e.g. drink more water, exercise more, remove avoidable stresses, etc.). Would you like help from us with accountability on these goals? Yes No
