LifeWorks FAMILY CHIROPRACTIC

#204, 1740 Gordon Drive ♦ Kelowna, BC ♦ V1Y 3H2 ♦ 250-868-4880

www.lifeworkschiropractic.ca wecare@lifeworkschiropractic.ca

Patient Introduction

Personal History:

Your Name: _____
First (Nick-name) Last

Your Mailing Address (including postal code please):

_____

_____

_____

Telephone: Home:_____ Bus: _____

Cell:_____ Email: _____

Birth Date: Day: _____ Month: _____ Year: _____Age_____

Marital Status:_____Partner's Name:_____

Children (names & ages) _____

Children (names & ages) _____

Occupation: _____

Employer: _____

Previous Chiropractor: _____ City: _____

Last visit to this Chiropractor:_____

Reason for leaving:

_____

_____

_____

Present MD: _____ City: _____

Referred to our Centre by:_____

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Adult Consultation History

Your Name: _____

Your Main Complaint: _____

Any other Complaints: _____

_____

How long have you suffered with this problem? _____

What have you tried to do to get rid of this problem that **DID NOT** work? _____

_____

_____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

_____

How does this problem interfere with the following areas of your life?

WORK: _____

FAMILY: _____

HOBBIES: _____

LIFE: _____

Does handling this problem cause stress for you? _____

_____

What do you do that makes this problem worse? _____

_____

How much older does this make you feel: _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

What gives you some temporary relief? _____

What is the pattern of this problem? Constant ___, Intermittent ___, Occasional ___ Cyclic ___

What is the effect it has on your body functions? _____

How did it start? _____

Are you on any type of medication?_____, Please list all: _____

_____

Could your problem have been caused by an injury at work?_____

If yes, please give us the details: _____

_____

_____

Have you been involved in an auto accident? _____

Date of accident: _____

Any difficulties from this?_____

_____

Is there any other information you would like us to know?_____

_____

_____

_____

_____

Do you have any children? _____

Do they have any health problems that you are aware of? _____

_____

SIGNATURE: _____ DATE: _____

For Women Only

Date of your last menstrual period: _____

Are using any means of contraception? _____

Do you experience severe cramping with your menstrual period? _____

Do you suffer from PMS? _____

Thank You!

FAMILY HEALTH HISTORY

Patient Name: _____ **Date:** _____

Please review the diseases and conditions listed below and indicate those that are **current health problems** of a family member by the designation **C** under his or her column. The **designation P** should be used **to indicate a past problem**. Leave blank those spaces that do not apply.

Condition	Self	Father	Mother	Spouse	Children		
					Age	Age	Age
ADHD							
Allergies							
Arthritis							
Asthma							
Autism							
Back Trouble							
Bed Wetting							
Bursitis							
Cancer							
Chest Pain							
Colic							
Constipation							
Crohn Disease							
Depression							
Diabetes							
Diarrhea							
Disc Problems							
Down Syndrome							
Ear Infection							
Emotion Issues							
Emphysema							
Epilepsy							
Headaches							
Migraines							
Heartburn							
Heart Trouble							
High Blood Press							
IBS							
Indigestion							
Infertility							
Insomnia							
Kidney Trouble							
Neck Pain							
Neuritis							
Nervousness							
Pinched Nerve							
Scoliosis							
Sinus Trouble							
Other							

Additional Comments:

_____

_____

_____

_____

HELP US UNDERSTAND YOUR HEALTH AND WELLNESS GOALS

Choosing chiropractic care is an exciting step towards regaining or improving your health and wellness. Old injuries, emotional tension, work and family situations along with poor dietary choices add to your daily stress load. This can cause muscles to overreact and joints within the spine to lock. However, our greatest concern is when those ongoing stressful habits affect the inner nerve connections, leaving you at risk for deeper health problems. Unwinding harmful spinal stress while coaching you towards a strong and vibrant lifestyle is what we love to do!

Our office uses a sophisticated scanning system to detect hidden stress patterns. This accurate, computer-based analysis rates your stress on a scale from 0-100 and is known as the **COREscore**™.

Please answer the following questions so we may better understand how to help you:

1. On a scale of 1 to 10 (10 being the most important) how important is your health to you? _____

On the COREscore™ chart to the right:

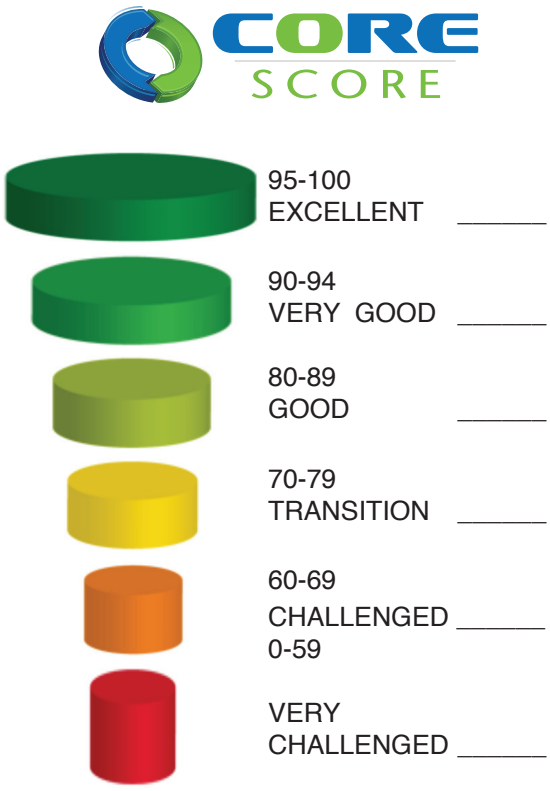
2. Please put an '**X**' to score where you think you are today.

3. Please circle where you would like to be (your goal).

4. How long do you think it might take to get to where you circled? _____

5. What things might you need to change to help you reach your goal?
   a. _____
   b. _____
   c. _____
   d. _____

6. If we could make recommendations that would not only address your main concerns, but could also help you with improving your overall health, would you like to hear them?
   _____ yes _____ no



www.MyCOREscore.com

Life Works
FAMILY CHIROPRACTIC
Helping You Express Your Full Life Potential