Almonte Chiropractic Centre

chiropractic www.almontechiropractic.com orthotics

Personal Information:

Name:_____ Pt # _____

Mailing Address: _____

City:_____ Postal Code: _____

Phone Home: _____ Work: _____ Cell:_____

DOB: _____ Age: _____ M/F Married / Single / Divorced / Widowed

Height: _____ Weight: _____ Shoe Size: _____

Occupation: _____ Email Address:_____

Medical Doctor: _____

Number of children: (names / ages / gender)

_____ _____

_____ _____

Who may we thank for referring you to our office? _____

Your Health Profile:

Completing this form is important. Our focus is on your ability to be healthy. Our goals are, first, to address the issue that brought you to this office, and second to offer you the opportunity of improved health potential and wellness. On a daily basis we experience physical, chemical and emotional stresses that accumulate and result in serious loss of health potential. Most times the effects are gradual, not even felt until they become serious or create symptoms. Answering the following questions will give us a profile of the specific stresses you have faced in your life and allow us to assess the challenges to your health potential.

Note: If you have no symptoms of pain and are here for a health and wellness check up, please skip to **General History** section.

① Please describe your chief health concern: _____

②

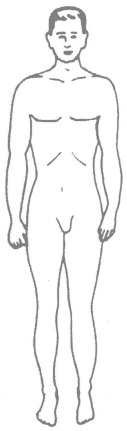
Health Concern	Severity 1=mild 10=worst	When did this episode start?	Dates of previous episodes?	Injury or trauma?

③ If you are in pain, is it?

Sharp Dull ache Constant Throbbing Burning Intermittent

Does the pain radiate / travel anywhere? **Yes / No**
(please use diagram to note location of your symptoms)

Since this condition began is it getting better, worse or staying the same? **B / W / S**



④ What makes it worse? (please circle)

Standing Walking Sitting Sleeping Bending Lifting

What makes you feel better? _____

⑤ On a scale of 1 - 10 how would you rate your present pain level?

1 (mild) 2 3 4 5 6 7 8 9 10 (severe)

⑥ This condition is interfering with my: (please circle)

Work Leisure activities Sleep Relationships Exercise Hobbies Attitude

Other: _____

⑦ Other professionals seen for your health care concerns?

Name: _____ Name: _____

Address: _____ Address: _____

What was done: _____ What was done: _____

General History:

⑧ Please check any of the following health conditions you have ever had, even if they are not related to your current problem:

☐ alcoholism	☐ diabetes	☐ constipation	☐ eczema/psoriasis	☐ cancer
☐ tuberculosis	☐ polio	☐ thyroid	☐ kidney stones	☐ osteoporosis
☐ stomach ulcers	☐ measles	☐ anemia	☐ heart disease	☐ allergies
☐ emphysema	☐ fatigue	☐ pneumonia	☐ multiple sclerosis	☐ infertility
☐ cold sores	☐ asthma	☐ epilepsy	☐ high blood pressure	☐ irritable bowel
☐ cirrhosis of liver	☐ depression	☐ migraines	☐ venereal disease	☐ menstrual problems
☐ ADHD	☐ stroke	☐ anxiety	☐ rheumatoid arthritis	☐ osteoarthritis
☐ miscarriages	☐ PMS	☐ heartburn	☐ ear infections	☐ sexual dysfunction

⑨ Are you taking any of the following medications or vitamin supplements?

☐ anti inflammatories _____ ☐ sedatives _____

☐ muscle relaxants _____ ☐ antibiotics _____

☐ birth control pills _____ ☐ insulin _____

☐ thyroid meds _____ ☐ blood pressure meds _____

☐ pain meds _____ ☐ antacids _____

☐ anti depressants _____ ☐ anti anxiety _____

☐ hormones _____ ☐ vitamins _____

⑩ Please list all surgeries and / or fractures you have had:

_____ date: _____

_____ date: _____

Have you had X-rays taken in the past 3 years?

Area of body: _____ Where? _____

Area of body: _____ Where? _____

Please list your top three stresses in each category:

Physical stress: (falls, accidents, work postures etc.)

Chemical stress: (smoke, alcohol, drugs, fast foods, missed meals, not drinking enough water)

Emotional stress: (work stress, difficult relationships, financial, poor self esteem etc.)

⑪ What do you currently do for exercise and how often? _____

⑫ Do you presently wear custom foot orthotics? **Y / N**

The beginning years: age 0 -18

Research is showing that many of the health challenges that occur later in life originated during the developmental year, some starting at birth. Please answer the following questions to the best of your ability.

Did you have any serious childhood illnesses?	Y	N	unsure
Did you have any serious falls or accidents as a child?	Y	N	unsure
Did you play youth sports?	Y	N	
Have you had prolonged use of an inhaler or antibiotics?	Y	N	unsure
Did you have any surgeries?	Y	N	unsure
Were you involved in any motor vehicle accidents?	Y	N	unsure
Were you exposed to emotional trauma?	Y	N	unsure
Were you vaccinated?	Y	N	unsure
Were you under regular chiropractic care as a child?	Y	N	unsure

Comments: _____

Adult 18 to present:

Do you / did you ever smoke?	Y	N	How much?	/ day
Do you drink alcohol?	Y	N	How much?	/ day
Do you drink coffee / tea / caffeinated beverages?	Y	N	How much?	/ day
Have you been in any car accidents?	Y	N		
Do you play an organized sport?	Y	N		
Do you commute to work > 30 min?	Y	N		
Do you belong to a health club?	Y	N		
Do you continue to get immunized?	Y	N		

Family Health Profile:

Many health problems are the result of hereditary spinal weaknesses and accumulated stress. Information about your immediate family members will give us a better picture of your overall health potential. (ie. stroke, heart attack etc.)

Please list below your family member's health history:

	Back pain	*Cancer*	*Heart*	*Asthma*	*Diabetes*	*Arthritis*	*Stroke*	*High Blood Pressure*	Other
Father:	☐	☐	☐	☐	☐	☐	☐	☐	_____
Mother:	☐	☐	☐	☐	☐	☐	☐	☐	_____
Brothers:	☐	☐	☐	☐	☐	☐	☐	☐	_____
Sisters:	☐	☐	☐	☐	☐	☐	☐	☐	_____
Spouse:	☐	☐	☐	☐	☐	☐	☐	☐	_____
Children:	☐	☐	☐	☐	☐	☐	☐	☐	_____

On a scale from 1 - 10 (1 being poor and 10 being excellent) please rate your:

eating habits: _____ exercise: _____ mental attitude: _____ sleep: _____

ability to deal with work stress: _____ ability to deal with home stress: _____

Rate your health and wellness:

Place an '**X**' where you believe your current level of health is.

Place an '**O**' indicating where you would like your wellness to be.

I hereby consent to a complete professional chiropractic examination and to any radiographic examinations that the doctor deems necessary. I understand that any fee for services rendered is due at the time of service.

I understand that my personal information will be kept confidential in accordance with the Registered Health Practitioners Act and Privacy Act.

Signature: _____ Date: _____

WOMEN ONLY:

Are you pregnant? Y / N / trying / unsure

Date of last menstrual cycle: _____

Thank you for filling out this form!

It is your first step to creating wellness!