WHOLE BODY *Health*

GENERAL INFORMATION

Welcome! Thank you for choosing Whole Body Health for your Chiropractic Care. We are committed to empowering you to make healthier lifestyle choices so you can live a more fulfilled and rewarding life.

Name:_____ Date:_____

Address:_____ Apt #: _____

City: _____ Postal Code: _____

Home Phone _____Work Phone_____

Cell _____Email _____

Would you like to receive helpful information from our office through email? ☐ yes ☐ no

Employer _____Occupation _____

Date of Birth ___M___ ___D___ ___Y___ Sex:_M / F_ Marital Status _____No. of Children____

Spouse/Partner's Name_____

Children's Names & Ages _____

What family members are currently under care in this office? _____

Have you ever received chiropractic care? ☐ yes ☐ no

If yes, when: _____ Dr.:_____How long: _____

Why did you see a Chiropractor? ☐ Wellness ☐ Specific Problem *(specify)*_____

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

M.D. Name:_____

WHOLE BODY *Health*

Dr. Shaelyn Osborn
Dr. Tanya Hintz-Parry
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www.mywholebodyhealth.com

PATIENT NAME _____ DOB M D Y _____ _____ _____

WHOLE BODY Health

COMPREHENSIVE HEALTH & WELLNESS PROFILE

The human body is designed to be healthy. Throughout life, events occur which damage your natural health expression. As a full spectrum Chiropractic office, we focus on your ability to be healthy.

Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. Your care will be designed to correct these layers of damage and recover your innate health!

There are many events that occur and habits that we pick up throughout our lifetime that may not allow us to maximize the expression of our optimal health potential. On a daily basis we experience physical, chemical and emotional stress that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious.

Answering the following questions will give us a better understanding of your overall health picture and help us develop an appreciation of the layers of damage, especially to your nervous system, that have resulted in poor health. It will help identify factors that may exist in your body which are blocking your body's innate ability to be healthy and well. It will also identify the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

CURRENT HEALTH CONCERNS THAT BROUGHT YOU TO OUR OFFICE

As the years go by and the layers of damage increase, it is common to begin to experience symptoms and random bouts of ill health until we are brought back to our optimal state of health.

How would your describe your current level of health? _____

_____

Present reason for consulting our office?

- ☐ Optimize health potential
- ☐ Improve health
- ☐ Correction and prevention of existing problem

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WHOLE BODY Health

PATIENT NAME _____ **DOB** M D Y

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

If you have no symptoms or concerns and are here for WELLNESS CARE, please check here ☐ and proceed to the Health History on Page 4.

What are your presenting health concerns? Please describe including the effect it has had on your life:

_____

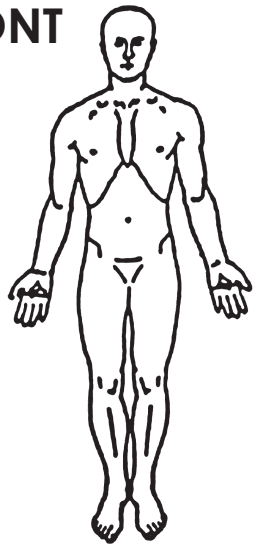
_____

_____

When did it begin? _____

Where is the problem? Please use the illustration and lines below to explain:

☐ **FRONT**



_____

_____

_____

_____

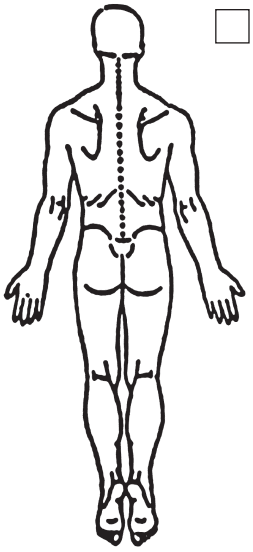
_____

_____

_____

_____

☐ **BACK**



Is it: ☐ getting worse ☐ improving ☐ intermittent (comes & goes) ☐ constant ☐ not sure

Do you have: ☐ pain ☐ numbness ☐ tingling ☐ aches

Is your pain: ☐ sharp ☐ dull ☐ throbbing ☐ constant ☐ intermittent (comes & goes)

Are your symptoms affected by: ☐ sitting ☐ standing ☐ walking ☐ bending ☐ lying down ☐ weather ☐ other _____

What makes it better? _____

What makes it worse? _____

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PATIENT NAME_____ **DOB** M D Y

Do you feel: ☐ cramps ☐ burning ☐ stiffness ☐ swelling ☐ other

Please explain: _____

_____

Do your symptoms interfere with: ☐ work ☐ sleep ☐ day-to-day activities

☐ play ☐ hobbies ☐ recreational activities ☐ other

Please explain: _____

_____

On a scale of 1 - 10 (1 = Least, 10 = Most) please rate the severity of your symptoms:

1 2 3 4 5 6 7 8 9 10

Have you done anything or seen anyone about this problem before coming to our office?

☐ yes ☐ no

Who have you seen and what have you tried? _____

Did that seem to work? _____

How concerned are you about this particular problem/symptom?

☐ not at all ☐ slightly ☐ moderately ☐ drastically

How concerned are you about your health?

☐ not at all ☐ slightly ☐ moderately ☐ drastically

Have you had this problem before? ☐ yes ☐ no If yes, when: _____

Why do you think it has come back? _____

Have you had x-rays taken of this area? ☐ yes ☐ no

When: _____ At what facility: _____

Secondary concerns: _____

_____

_____

_____

_____

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WHOLE BODY Health

PATIENT NAME _____ **DOB** M D Y

HEALTH HISTORY

Do you have or have you had, any of the following (please check all that apply):

	Have	Had		Have	Had		Have	Had		Have	Had
Pneumonia	☐	☐	Anemia	☐	☐	Rheumatic Fever	☐	☐	Diabetes	☐	☐
Pleurisy	☐	☐	Rashes	☐	☐	Thyroid Disease	☐	☐	Measles	☐	☐
Eplilepsy	☐	☐	Influenza	☐	☐	Whooping Cough	☐	☐	Stroke	☐	☐
Eczema	☐	☐	Chickenpox	☐	☐	Heart Disease	☐	☐	Polio	☐	☐
Colitis	☐	☐	Arthritis	☐	☐	Depression	☐	☐	Cancer	☐	☐
Mumps	☐	☐	Allergies:	☐	☐	*List allergies:*					

If you have ever been diagnosed with another disease or condition, please describe:

_____

Do you drink: ☐ coffee ☐ tea ☐ alcohol

Do you use: ☐ cigars/cigarettes ☐ recreational drugs ☐ artificial sweeteners ☐ sugar

Do you have or have you had, any of the following (please check all that apply):

	Have	Had		Have	Had		Have	Had
neck pain	☐	☐	sinus problems	☐	☐	excessive urination	☐	☐
low back pain	☐	☐	frequent colds	☐	☐	discoloured urine	☐	☐
headaches	☐	☐	weight loss	☐	☐	gas/bloating	☐	☐
migraines	☐	☐	poor appetite	☐	☐	heartburn	☐	☐
arm pain/tingling	☐	☐	excessive appetite	☐	☐	irritable bowel	☐	☐
shoulder pain	☐	☐	nervousness	☐	☐	black or bloody stools	☐	☐
hand pain/tingling	☐	☐	confusion	☐	☐	ulcers	☐	☐
leg pain/tingling	☐	☐	irritability	☐	☐	constipation	☐	☐
jaw pain	☐	☐	depression	☐	☐	diarrhea	☐	☐
chest pain	☐	☐	sleep problems	☐	☐	hemorrhoids	☐	☐
lung problems	☐	☐	dental problems	☐	☐	liver problems	☐	☐
heart problems	☐	☐	excessive thirst	☐	☐	paralysis	☐	☐
abnormal blood pressure	☐	☐	frequent nausea	☐	☐	numbness	☐	☐
irregular heartbeat	☐	☐	prostate problem	☐	☐	fatigue	☐	☐
ankle swelling	☐	☐	breast pain/lump	☐	☐	dizziness	☐	☐
cold extremities	☐	☐	menstrual pain/problems	☐	☐	fainting	☐	☐
blurred vision	☐	☐	muscle cramps	☐	☐	ringing in the ears	☐	☐
vision problems	☐	☐	painful urination	☐	☐	difficulty hearing	☐	☐
difficulty breathing	☐	☐	bladder trouble	☐	☐	ear pain	☐	☐
other (list):	☐	☐						

PATIENT NAME_____ **DOB** M D Y

STRESS HISTORY

All stress can cause or contribute to subluxations & neurospinal problems. To better understand your health & well-being it is important that we review your stress history.

BIRTH STRESS & YOUR CHILDHOOD YEARS (Neonatal to age 18)

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

	Yes	No	Unsure	Describe/Explain
Did your mother have a difficult pregnancy with you ?	☐	☐	☐	
Did your mother have any falls, accidents or physical injuries during pregnancy?	☐	☐	☐	
Was your birth traumatic?	☐	☐	☐	
Location of your birth: ☐ hospital ☐ birthing centre ☐ home ☐ not sure				
Was your birth: ☐ induced ☐ natural ☐ c-section ☐ forceps/suction ☐ breech ☐ prolonged ☐ other				
Did your mother smoke, drink alcohol, or take medication or drugs while pregnant with you?	☐	☐	☐	
Were you breastfed?	☐	☐	☐	How long? _____ years _____ months
Did you have any childhood illnesses?	☐	☐	☐	
Did you have any serious falls as a child?	☐	☐	☐	
Did you have any broken bones (fractures) as a child?	☐	☐	☐	
Did you play sports as a child?	☐	☐	☐	
Did you take / use any drugs or medication as a child?	☐	☐	☐	
Did you have any surgery as a child?	☐	☐	☐	
Have you been hospitalized as a child?	☐	☐	☐	
Were you involved in any car accidents as a child?	☐	☐	☐	
Any other traumas as child - physical or emotional?	☐	☐	☐	
Were you vaccinated?	☐	☐	☐	
Any vaccine reactions?	☐	☐	☐	
As a child, were you under regular Chiropractic care?	☐	☐	☐	

PATIENT NAME _____ **DOB** M D Y

ADULT STRESS (Age 18 to Present)

	Yes	No	Unsure	Describe/Explain
Do / did you smoke?	☐	☐	☐	
Do / did you drink alcohol?	☐	☐	☐	
Are you or have you ever been overweight?	☐	☐	☐	
Do you experience work stress?	☐	☐	☐	
Do you experience physical stress?	☐	☐	☐	
Are you experiencing mental / emotional stress?	☐	☐	☐	
Do you have poor posture?	☐	☐	☐	
Have you been in any auto accidents as an adult?	☐	☐	☐	
Any traumatic accidents as an adult?	☐	☐	☐	
Any notable falls or injuries as an adult?	☐	☐	☐	
Any broken bones (fractures) as an adult?	☐	☐	☐	
Have you had any surgeries as an adult?	☐	☐	☐	
Any complications from surgery?	☐	☐	☐	
Have you been hospitalized as an adult?	☐	☐	☐	
Have you had extensive dental work, orthodontics, or jaw problems?	☐	☐	☐	
Do you exercise regularly?	☐	☐	☐	
Do / did you play any adult sports?	☐	☐	☐	
Do you wake up refreshed?	☐	☐	☐	

How old is your mattress?_____years Do you sleep regular hours? ☐ yes ☐ no

What position do you sleep in? ☐ back ☐ side ☐ stomach

How many hours per night do you sleep?_____ hours

How many hours per day do you spend sitting? _____ hours

Please list any medications you are currently taking (include birth control, Tylenol/Advil, anti-histamines, etc):

Medication	**What it is for:**	**When you started taking it:**	**Any side effects:**

PATIENT NAME_____ DOB M D Y

LIFESTYLE STRESS

On a scale of 1 - 10 (1 = Low, 10 = High) please rate:

Your stress from:

Work/School	1	2	3	4	5	6	7	8	9	10
Family or personal relationships	1	2	3	4	5	6	7	8	9	10
Loss of loved one(s)	1	2	3	4	5	6	7	8	9	10
Health problems	1	2	3	4	5	6	7	8	9	10
Change in lifestyle	1	2	3	4	5	6	7	8	9	10
Change in job or career	1	2	3	4	5	6	7	8	9	10
Other(s)_____ _____	1	2	3	4	5	6	7	8	9	10
Your current overall stress level	1	2	3	4	5	6	7	8	9	10

Is your stress constant? ☐ yes ☐ no

Please explain? _____

On a scale of 1 - 10 (1 = Poor, 10 = Excellent) please rate:

Your physical health	1	2	3	4	5	6	7	8	9	10
Your emotional health	1	2	3	4	5	6	7	8	9	10

Your satisfaction with:

Work	1	2	3	4	5	6	7	8	9	10
Family relationships	1	2	3	4	5	6	7	8	9	10
Achievements	1	2	3	4	5	6	7	8	9	10
Other(s)_____ _____										

Do you think any aspects of your lifestyle contribute to your health problems? ☐ yes ☐ no

Please explain? _____

Describe your diet and eating habits _____

_____

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PATIENT NAME _____ **DOB** M D Y

FAMILY HISTORY

Is there a Family History of:

	Mother's Side	Father's Side
Heart Disease	☐	☐
Stroke	☐	☐
Cancer	☐	☐
Arthritis	☐	☐
Diabetes	☐	☐
Other	☐	☐

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Other _____

ABOUT YOUR CARE

Chiropractic provides three types of care. The first is Initial Intensive Care, which corrects the most recent layer of Spinal and Neurological damage. This care usually reduces or eliminates the symptoms. Then begins Corrective Care, which corrects the years of damage that occurred when there were few symptoms. And finally, Chiropractic offers a genuine approach to Wellness Care. All of these options will be explained at your Report of Findings. Then you will be able to begin a course of care that fits your health goals.

I consent to a professional and complete chiropractic examination as the doctor deems necessary. I understand that any fee for services rendered is due at the time of service and cannot be deferred to a later date.

SIGNATURE _____ **DATE** _____