

What is the **PRIMARY PROBLEM** for which you are seeking chiropractic care? _____

Where is the location of your Primary problem? left right center both sides upper lower
How long have you been dealing with this problem? _____ days _____ weeks _____ months _____ years
How often does this problem affect you? _____ x/day _____ x/week _____ x/month

Circle on a scale of 1-10 how you would rate your discomfort

NO PAIN 1...2...3...4...5...6...7...8...9...10 EXTREME PAIN

How would you describe what you feel?

- | | | | |
|-----------------------------------|-----------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> stabbing | <input type="checkbox"/> tingling | <input type="checkbox"/> burning | <input type="checkbox"/> sore |
| <input type="checkbox"/> sharp | <input type="checkbox"/> shooting | <input type="checkbox"/> radiating | <input type="checkbox"/> dull/aching |
| | | <input type="checkbox"/> localized | <input type="checkbox"/> other _____ |

How has this affected your life? What are you hoping to improve in your life with Chiropractic Care? _____

Is there a **SECONDARY PROBLEM** for which you are seeking chiropractic care? _____

Where is the location of your secondary problem? left right center both sides upper lower
How long have you been dealing with this problem? _____ days _____ weeks _____ months _____ years
How often does this problem affect you? _____ x/day _____ x/week _____ x/month

Circle on a scale of 1-10 how you would rate your discomfort

NO PAIN 1...2...3...4...5...6...7...8...9...10 EXTREME PAIN

How would you describe what you feel?

- | | | | |
|-----------------------------------|-----------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> stabbing | <input type="checkbox"/> tingling | <input type="checkbox"/> burning | <input type="checkbox"/> sore |
| <input type="checkbox"/> sharp | <input type="checkbox"/> shooting | <input type="checkbox"/> radiating | <input type="checkbox"/> dull/aching |
| | | <input type="checkbox"/> localized | <input type="checkbox"/> other _____ |

How has this affected your life? What are you hoping to improve in your life with Chiropractic Care? _____

SPINAL STRESSORS AND TRAUMAS

MOTORIZED VEHICLE ACCIDENTS

Year: _____ Injuries: _____

Year: _____ Injuries: _____

Year: _____ Injuries: _____

High speed collision? >40Km/hr Whiplash Injury?

Seat belted? Y N Other: _____

FALLS (Childhood and Beyond)

From Heights: _____

Falls Downstairs: _____

Other Falls: _____

Broken Bones/Fractures: _____

POSTURES AND HABITS

Sitting >6hrs/day Stomach Sleeper

Forward Head Posture

CONCERNING FAMILY HISTORY

Parents/Siblings: _____

Spouse/Children: _____

SPORTS AND RECREATION

What sports do you participate in? _____

Please list notable sports related injuries: _____

OCCUPATIONAL STRESS: my job requires:

Long Sitting Periods Heavy Lifting

Awkward Positions Repetitive Stress

Poor Ergonomics Other: _____

MAJOR OPERATIONS/ILLNESSES

Year: _____ Details: _____

Year: _____ Details: _____

Year: _____ Details: _____

BIRTH TRAUMA (Your Own Delivery)

Difficult Epidural C-Section

Premature Suction/forceps Unsure

PRIMARY DAILY ACTIVITIES:

sitting walking telephone

standing desk/computer manual repetitive

driving heavy labour other: _____

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in your lowered state of health. At your report of findings, Dr Lianne/Dr Kayla will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

MEDICATIONS /SUPPLMENTS USED WITHIN THE PAST 6 MONTHS: _____

Past Health: Have you ever suffered from any of the following conditions? Please check all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Thyroid trouble | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Epileptic Seizures |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Polio | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> HIV | |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke | |

Present Health: Are you presently affected by any of the following? (Within the past 3 months)

Please check the boxes that apply: **O-OCCASIONAL F-FREQUENT C-CONSTANT**

MUSCLE AND JOINT	O F C	EYE EAR NOSE THROAT	O F C	GASTROINTESTINAL	O F C
Neck Pain.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Asthma.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Indigestion.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Shoulder Pain.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sinus Trouble.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Gas Pains.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low Back Pain.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Tonsillitis.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Nausea or Vomiting.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Knee Trouble.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Sore Throat.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Stomach Pains.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Foot Trouble.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Earache.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Constipation.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Arthritis.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Deafness.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Heartburn.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Hernia.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			Diarrhea.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Spinal Curvature.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	STRESS SYMPTOMS		Colon Trouble.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Faulty Posture.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Headache.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Liver Trouble.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Sciatica.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Migraines.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Bladder Trouble.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Painful Tailbone.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Dizziness.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Kidney Trouble.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		Ringing in Ears.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood Stools.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
CARDIOVASCULAR		Loss of Sleep.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Rapid Heart Beat.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blurring of Vision.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	URINARY	
High Blood Pressure.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Loss of Concentration.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Painful Urination.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Low Blood Pressure.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Loss of Memory.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Waking at Night to Urinate.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Pain Over Heart.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Irritable/Nervousness.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Increased Urination.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Swelling of Ankles.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Depression.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Blood in Urine.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Poor Circulation.....	Y <input type="checkbox"/> N <input type="checkbox"/>	Decreased Energy/Fatigue.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
		Tension.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	FEMALES ONLY	
GENERAL SYMPTOMS		Numbness or Pins and Needles:		Painful Menstruation.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Fever/Chills/Sweating.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	In Arms/Hands.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Irregular Periods.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Fainting.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	In Legs/Feet.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Passed Menopause.....	Y <input type="checkbox"/> N <input type="checkbox"/>
Convulsions.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	RESPIRATORY		Menopausal Symptoms.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Allergy.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chronic Cough.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Birth Control Pill.....	Y <input type="checkbox"/> N <input type="checkbox"/>
Skin Problems.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Spitting Up Phlegm/Blood.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Other Birth Control Methods:	
Colds.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Chest Pain.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Tremors.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Difficulty Breathing.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Date of Last Menstruation:	
Loss of Balance.....	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				

Informed consent to chiropractic adjustments and care

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients of benefits and risks including sprain/strain, rib fracture, disc herniation and with neck problems of the following: there have been very rare incidents of injury to the vertebral artery during the course of treatment. This may have caused strokes or stroke like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays have been performed on you to minimize these risks. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions about this, please ask your chiropractor. If you read the above statement and consent to the exam and treatment if you choose to start care, please sign below.

Signature _____

Date _____

Thank you. Please turn the page. ~3

MY GOALS

We believe all of our patients have individual goals and we want to make sure we can help you move towards those goals. Your goals can encompass: health, physical, emotional, spiritual and financial factors.

<p>Short Term Goals Where do you want to see yourself in 3-6 months?</p>	<p><i>e.g. "I want to sleep better", "I want to wake up without pain", "I want to lose 10lbs"</i></p>
<p>Middle Term Goals Where do you want to see yourself in 1-5 years?</p>	<p><i>e.g. "I want to compete in a triathlon", "I want to have kids", "I want to get back to my normal activities (please specify)"</i></p>
<p>Long Term Goals Where do you want to see yourself in 10-15 years?</p>	<p><i>e.g. "I want to have my dream job", "I want to travel the world"</i></p>

How **motivated** are you to achieving your **goals**?

Not Motivated					Moderately Motivated					100% Motivated!
1	2	3	4	5	6	7	8	9	10	