PERSONAL HEALTH PROFILE

Patient's Name (including middle initial)_____ _____ _____ Date _____

Address _____ Postal Code _____

Res. Phone _____ Bus. Phone _____ Cell _____ Age _____

Birthdate _____ Height _____ Weight _____ # of children _____ email _____

Occupation _____ Employer _____ Name of Spouse _____
(or parent if minor)

Who referred you here or how did you learn of our office? _____

BC Care Card # _____

Do you currently qualify for premium assistance with the Medical Services Plan of British Columbia? □ yes □ no

Spinal subluxations have a significant impact on your health and well-being. Please answer the following important questions to the best of your ability, in as much detail as is practical.

Early Childhood History

Describe all <u>childhood</u> impacts, especially hard falls, sports or car accidents, concussions, broken bones, etc.:

_____

_____

Please describe all significant or chronic childhood illnesses: _____

Were you given any prolonged doses of medications, such as antibiotics or inhalers? _____

Did you suffer any significant emotional traumas as a child? _____

As a child, did you receive regular chiropractic care? _____ Doctor's name? _____

Your Current History

Briefly describe your chief complaint, it's location and the effect it has had on your life: _____

_____

How long has this problem been present? _____ Have you ever had this problem in the past? _____

If so, when? _____ What do <u>you</u> think is *the cause* of your problem? _____

If you are experiencing pain, is it… _____ sharp _____ dull _____ comes/goes _____travels _____constant

What makes the problem worse? _____ What makes it better? _____

What specific life activities does it interfere with (work, sleep, leisure, etc?) _____

Is your complaint related to a motor vehicle accident? □ yes □ no Is it related to a Worker's Comp. Injury? □ yes □ no

Other Doctors seen for this problem (please list)

Chiropractor _____ Medical Doctor _____ Other _____

On a scale of 1 – 10 describe your current stress level: (1=none/ 10=extreme) Occupational _____ Personal _____

Please describe the following as either, poor, fair, good, or excellent:

Diet _____ Exercise _____ Sleep _____ Posture _____ General Health _____

Have you had x-rays of your spine within the last year? _____ If so, where were they taken? _____

Most people have had literally dozens of impact/stresses that can cause subluxations.

When was your most recent auto accident? _____ Front / side / rear-end collision? _____

Describe your most recent stress or strain while working _____

What sport or recreational activities do you do? _____

When was your most recent stress or strain during these activities? _____

Is there any other injury that you have had, minor or major, that we should know about? _____

_____

Please put a "**C**" beside each symptom which you currently have (or experience on a recurring basis);
Please put a "**P**" beside each symptom you have had in the past.

____ Headaches	____ Pins & Needles in Legs	____ Fainting	____ Neck pain
____ Pins & Needles in Arms	____ Loss of Smell	____ Back pain	____ Loss of balance
____ Dizziness	____ Ringing in ears	____ Loss of hearing	____ Nervousness
____ Numbness in fingers	____ Numbness in toes	____ Loss of taste	____ Stomach upset
____ Fatigue	____ Depression	____ Irritability	____ Tension
____ Sleeping Problems	____ Stiff neck	____ Cold hands	____ Cold feet
____ Diarrhea	____ Constipation	____ Fever	____ Hot flashes
____ Cold sweats	____ Light bothers eyes	____ Problem urinating	____ Heartburn
____ Mood Swings	____ Menstrual pain	____ Breathing difficulty	____ Ulcers
____ Seizures	____ Menstrual Irregularity	____ Jaw problems	____ Sinus problems

List all drugs (medications) you are taking: _____

List any chronic disease(s) you may have: (arthritis, diabetes, cancer, heart disease, rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, etc.)

_____

Other Comments:

_____

The statements made on this form are true to the best of my memory and I agree to allow this office to examine me for further evaluation:

Signature _____ Date _____