



ADULT PATIENT HEALTH RECORD

CONFIDENTIAL

PATIENT #: _____

(For internal use only)

DATE: _____

PERSONAL INFORMATION

Name _____ Address _____

City _____ Province _____ Postal Code _____ Gender M F

Phone: 1) Home _____ 2) Cell _____ 3) Business _____

Email address _____ Date of birth _____

Business/Employer _____ Type of work _____

Emergency Contact _____ Phone _____ Relationship _____

Whom shall we thank for referring you to our office? _____

Reason for consulting our office today? _____

YOUR HEALTH PROFILE

Why this form is important ... As a full-spectrum chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in postural distortions which can have serious repercussions on your health and your performance. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (birth to age 17)

Research is showing that most 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:

When you were born, were you delivered: Naturally Home Birth Hospital C-Section
 (Check all that apply) Drug induced Forceps Vacuum Unsure

	YES	NO	COMMENT
•Have you fallen/jumped from a height of over 3 feet (ie, crib, change table, playground equipment, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
•Any serious falls as a child (over 4 feet)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
•Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
•Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	_____
•Did you have any surgery as a child?	<input type="checkbox"/>	<input type="checkbox"/>	_____
•Did you receive any chiropractic care as a child?	<input type="checkbox"/>	<input type="checkbox"/>	_____
•Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	_____
•Any substance abuse (drugs or alcohol)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
•Was there any prolonged use of medicine (ie, antibiotics, inhalers, painkillers, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	_____
•Were you hospitalized for any serious illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
•Were you subjected to any emotional traumas? (Abuse of any kind, loss, parents separating/divorcing, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Adult Years (18 to present)

YES NO

COMMENT

- Have you ever been in a motor vehicle accident? When? YES NO _____
- If 'yes', were you examined by a chiropractor? YES NO _____
- Any notable falls or injuries as an adult? YES NO _____
- Any broken bones as an adult? YES NO _____
- Do you or did you play contact sports of any kind? YES NO _____
- Any hobby or sports-related injuries? YES NO _____
- Work-related injuries? YES NO _____
- Were you taught proper sitting techniques? YES NO _____
- Were you taught proper lifting techniques? YES NO _____
- Have you had any surgery as an adult? YES NO _____
- Do you exercise regularly? YES NO _____
- Is your job physically demanding? YES NO _____
- Do you sit most of the time at work? YES NO _____
- Do you typically sleep on your back, side, or stomach? YES NO _____
- Have you been hospitalized as an adult? YES NO _____
- Have you had previous chiropractic care as an adult? YES NO _____
- Do you have (check all that apply): Osteoarthritis Rheumatoid arthritis Osteoporosis Cancer

- Did you or do you smoke? YES NO _____
- Did you or do you drink alcohol? YES NO _____
- Did you or do you use recreational drugs? YES NO _____
- Did you or do you use over-the-counter medication? YES NO _____
- Did you or do you take prescription medication? YES NO _____
- Did you or do you have any substance abuse issues? YES NO _____
- Do you eat as healthy as you think you should? YES NO _____
- Are you or have you ever been overweight? YES NO _____

•What is your level of mental-emotional stress on a scale of 1 (none) to 10 (severe)? (ie, relationship issues, mental health issues, job insecurity, finances, etc) _____

•For women: Are you pregnant? Yes No Trying Unsure Date of last menstrual period: _____

If you have no specific symptoms or complaints, and are here mainly for wellness services, please check (x) here _____ and skip to “**Family Health Profile**” (page 3). Those who have symptoms or complaints need to briefly describe the chief area of complaint, including the affect it has on your life. _____

If you are experiencing pain, is it: Sharp Dull Comes and Goes Travels Constant

Since the problem started, it is: About the same Getting better Getting worse

What makes it worse? _____

It interferes with: Work Sleep Walking Sitting Hobbies Leisure

Names of other Doctors seen for this problem:

Chiropractor _____

Medical Doctor _____

Other _____

What did you like or dislike about their methods of treatment? _____

If you have experienced this same problem(s) before, why do you think it came back? _____

Why do you think chiropractic will help? _____

What would you like to see done differently in your care at this office? _____

How long do you think it will take us to help you? _____

Please rate your level of commitment to resolving this/these problem(s): (1 = least/10 = highest) _____

Family Health Profile

Is there a family history of:

	Heart Disease	Stroke	Cancer	Arthritis	Diabetes	Other
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please check ALL of the following you have EVER had, even if you don't think they are related to the current problem:

POSTURE QUADRANT 1	POSTURE QUADRANT 2	POSTURE QUADRANT 3	POSTURE QUADRANT 4	
<input type="checkbox"/> Stress <input type="checkbox"/> Anxiety (GAD) <input type="checkbox"/> Attention Deficit Hyperactivity Disorder <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Whiplash <input type="checkbox"/> Vertigo <input type="checkbox"/> Dizziness <input type="checkbox"/> Jaw pain <input type="checkbox"/> Imbalance <input type="checkbox"/> Sinus pressure/headaches <input type="checkbox"/> Fatigue <input type="checkbox"/> Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Confusion/forgetfulness <input type="checkbox"/> Neck pain <input type="checkbox"/> Nervousness <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> TIA <input type="checkbox"/> Buzzing/ringing ears	<input type="checkbox"/> Stroke <input type="checkbox"/> Decreased lung capacity <input type="checkbox"/> Facial numbness <input type="checkbox"/> Facial pain <input type="checkbox"/> Depression <input type="checkbox"/> Pinched nerve (neck) <input type="checkbox"/> Poor eyesight <input type="checkbox"/> Chronic fatigue syndrome <input type="checkbox"/> Chronic infections <input type="checkbox"/> Thyroid issues <input type="checkbox"/> Asthma/allergies <input type="checkbox"/> Herniated disc <input type="checkbox"/> Mood swings <input type="checkbox"/> Frequent nausea <input type="checkbox"/> Decreased immunity/frequent colds <input type="checkbox"/> Decreased energy/fatigue <input type="checkbox"/> Difficulty losing weight <input type="checkbox"/> Blood pressure trouble	<input type="checkbox"/> Pain between shoulders <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest pains <input type="checkbox"/> Breast pains <input type="checkbox"/> Liver/gall bladder problems <input type="checkbox"/> Ulcers/heartburn <input type="checkbox"/> Upset stomach <input type="checkbox"/> Postural concerns <input type="checkbox"/> Diabetes <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Arm pain <input type="checkbox"/> Elbow pain <input type="checkbox"/> Wrist/hand/finger pain <input type="checkbox"/> Numbness/tingling in upper extremities <input type="checkbox"/> Muscle tension in shoulders/upper back <input type="checkbox"/> Frozen shoulder syndrome <input type="checkbox"/> Humping of upper back <input type="checkbox"/> Carpal tunnel syndrome <input type="checkbox"/> Swelling in wrists/hands/fingers <input type="checkbox"/> GERD <input type="checkbox"/> Scoliosis <input type="checkbox"/> Uneven shoulders <input type="checkbox"/> Circulatory/heart problems <input type="checkbox"/> Respiratory/lung problems	<input type="checkbox"/> Poor stability <input type="checkbox"/> Pinched nerve <input type="checkbox"/> Numbness/tingling in lower extremities <input type="checkbox"/> Herniated disc <input type="checkbox"/> Menstrual irregularity <input type="checkbox"/> Infertility <input type="checkbox"/> Miscarriage(s) <input type="checkbox"/> Trouble conceiving <input type="checkbox"/> Menstrual cramps <input type="checkbox"/> Pain/stiffness in the morning <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Irritable Bowel (IBS) <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Bladder trouble/painful urination <input type="checkbox"/> Low back pain <input type="checkbox"/> Uneven hips <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Sexual dysfunction <input type="checkbox"/> Abdominal pains <input type="checkbox"/> "Back goes out" syndrome <input type="checkbox"/> Weakness when lifting <input type="checkbox"/> Pain when sitting <input type="checkbox"/> Pain when standing <input type="checkbox"/> Sciatica (leg pain) <input type="checkbox"/> Protruding belly <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Groin strain <input type="checkbox"/> Hamstring strain	<input type="checkbox"/> Hip pain <input type="checkbox"/> Walking problems <input type="checkbox"/> Knee pain <input type="checkbox"/> Shin pain <input type="checkbox"/> Bunions <input type="checkbox"/> Arthritis in hip(s) <input type="checkbox"/> Arthritis in knee(s) <input type="checkbox"/> Foot pain <input type="checkbox"/> Flat feet/fallen arches <input type="checkbox"/> Sprained knee(s) <input type="checkbox"/> Sprained ankle(s) <input type="checkbox"/> Tight calves <input type="checkbox"/> Knock knees <input type="checkbox"/> Bow legs <input type="checkbox"/> Heel spurs <input type="checkbox"/> Achilles tendon strain/rupture <input type="checkbox"/> Ankle swelling <input type="checkbox"/> Plantar Fasciitis

Patient's signature _____

Date _____

CONSENT TO TREATMENT WITH LIFE CHIROPRACTIC CENTRE

Our clinic is dedicated to assisting you in recovering your health naturally. Please review the following and sign in the area provided below:

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment to the doctor. All fees are due at time of service unless other arrangements have been made and agreed upon by both parties.

I hereby request and consent to the performance of any necessary chiropractic procedures, and if necessary, diagnostic x-rays on me by the doctor of chiropractic named below and/or anyone working in this office or clinic personnel, the nature and purpose of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic named below.

I have had an opportunity to discuss with the doctor of chiropractic/staff members named below and/or with other office or clinic personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I further understand and am informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, skin irritation (from laser therapy), strains and sprains, rib fracture, disc injuries and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known and in my best interest.

I agree to Life Chiropractic Centre collecting and using personal information about me as set out in their Privacy Policy, which I have the right to review at any time.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

Name (please print): _____ **Guardian's name (if applicable):** _____

Patient or legal guardian's signature: _____ **Date:** _____

Chiropractor's signature: _____ **Date:** _____

By signing this document, I understand fully and completely all terms and conditions set forth regarding my treatment with Life Chiropractic Centre.