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: *(Check all that apply)*

Naturally ☐	Home Birth ☐	Hospital ☐	C-Section ☐
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)?	☐	☐	____________
•Any serious falls as a child (over 4 feet)?	☐	☐	____________
•Did you play youth sports?	☐	☐	____________
•Were you involved in any car accidents as a child?	☐	☐	____________
•Did you have any surgery as a child?	☐	☐	____________
•Did you receive any chiropractic care as a child?	☐	☐	____________
•Were you vaccinated?	☐	☐	____________
•Any substance abuse (drugs or alcohol)?	☐	☐	____________
•Was there any prolonged use of medicine (ie, antibiotics, inhalers, painkillers, etc)?	☐	☐	____________
•Were you hospitalized for any serious illnesses?	☐	☐	____________
•Were you subjected to any emotional traumas? (Abuse of any kind, loss, parents separating/divorcing, etc)	☐	☐	____________

Adult Years (18 to present)

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

•Do you have (check all that apply): □ Osteoarthritis □ Rheumatoid arthritis □ Osteoporosis □ Cancer

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

•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 (×) 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

<u>Names of other Doctors seen for this problem:</u>

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	☐	☐	☐	☐	☐	____________
Father's Side	☐	☐	☐	☐	☐	____________

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

- ☐ Stress
- ☐ Anxiety (GAD)
- ☐ Attention Deficit Hyperactivity Disorder
- ☐ Loss of sleep
- ☐ Whiplash
- ☐ Vertigo
- ☐ Dizziness
- ☐ Jaw pain
- ☐ Imbalance
- ☐ Sinus pressure/ headaches
- ☐ Fatigue
- ☐ Headaches
- ☐ Migraines
- ☐ Confusion/ forgetfulness
- ☐ Neck pain
- ☐ Nervousness
- ☐ Fibromyalgia
- ☐ TIA
- ☐ Buzzing/ringing ears
- ☐ Stroke
- ☐ Decreased lung capacity
- ☐ Facial numbness
- ☐ Facial pain
- ☐ Depression
- ☐ Pinched nerve (neck)
- ☐ Poor eyesight
- ☐ Chronic fatigue syndrome
- ☐ Chronic infections
- ☐ Thyroid issues
- ☐ Asthma/allergies
- ☐ Herniated disc
- ☐ Mood swings
- ☐ Frequent nausea
- ☐ Decreased immunity/ frequent colds
- ☐ Decreased energy/ fatigue
- ☐ Difficulty losing weight
- ☐ Blood pressure trouble

POSTURE QUADRANT 2

- ☐ Pain between shoulders
- ☐ Shortness of breath
- ☐ Chest pains
- ☐ Breast pains
- ☐ Liver/gall bladder problems
- ☐ Ulcers/heartburn
- ☐ Upset stomach
- ☐ Postural concerns
- ☐ Diabetes
- ☐ Shoulder pain
- ☐ Arm pain
- ☐ Elbow pain
- ☐ Wrist/hand/finger pain
- ☐ Numbness/tingling in upper extremities
- ☐ Muscle tension in shoulders/upper back
- ☐ Frozen shoulder syndrome
- ☐ Humping of upper back
- ☐ Carpal tunnel syndrome
- ☐ Swelling in wrists/ hands/fingers
- ☐ GERD
- ☐ Scoliosis
- ☐ Uneven shoulders
- ☐ Circulatory/heart problems
- ☐ Respiratory/lung problems

POSTURE QUADRANT 3

- ☐ Poor stability
- ☐ Pinched nerve
- ☐ Numbness/tingling in lower extremities
- ☐ Herniated disc
- ☐ Menstrual irregularity
- ☐ Infertility
- ☐ Miscarriage(s)
- ☐ Trouble conceiving
- ☐ Menstrual cramps
- ☐ Pain/stiffness in the morning
- ☐ Crohn's Disease
- ☐ Irritable Bowel (IBS)
- ☐ Ulcerative Colitis
- ☐ Bladder trouble/ painful urination
- ☐ Low back pain
- ☐ Uneven hips
- ☐ Diarrhea/ Constipation
- ☐ Sexual dysfunction
- ☐ Abdominal pains
- ☐ "Back goes out" syndrome
- ☐ Weakness when lifting
- ☐ Pain when sitting
- ☐ Pain when standing
- ☐ Sciatica (leg pain)
- ☐ Protruding belly
- ☐ Urinary incontinence
- ☐ Groin strain
- ☐ Hamstring strain

POSTURE QUADRANT 4

- ☐ Hip pain
- ☐ Walking problems
- ☐ Knee pain
- ☐ Shin pain
- ☐ Bunions
- ☐ Arthritis in hip(s)
- ☐ Arthritis in knee(s)
- ☐ Foot pain
- ☐ Flat feet/fallen arches
- ☐ Sprained knee(s)
- ☐ Sprained ankle(s)
- ☐ Tight calves
- ☐ Knock knees
- ☐ Bow legs
- ☐ Heel spurs
- ☐ Achilles tendon strain/rupture
- ☐ Ankle swelling
- ☐ Plantar Fasciitis

Patient's signature ____________________________________ **Date**________________________

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CONSENT TO TREATMENT PROCESS 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 examination, chiropractic procedures, cold laser therapy, 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.

Patient's Name (please print): ________________________ **Parent or Guardian's Name** (if applicable): ____________________

Patient or Parent/Guardian's Signature: ____ **Date:** __________________

Chiropractor's Name: ____________________________ **Signature** ___________________________ **Date:** __________________

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