Seeley's Bay Family Chiropractic

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CONFIDENTIAL PATIENT INFORMATION

Name: _____ Date: _____

Phone: Res: _____ Bus: _____ Cell: _____

Email: _____

Address: _____ City: _____ Postal Code: _____

Date of Birth: (m/d/y) _____ Single__ Married__ CommonLaw__ Div__ Sep__ Widow/er__

No of Children: _____ Family Physician: _____

Occupation: _____ No of Years: _____ Employer: _____

Health Card# _____ Version Code: _____

Who may we Thank for referring you to your office? _____

Your Health Profile

As a full spectrum solution based Chiropractic office. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity to improve you health potential and wellness. On a daily bases we experience physical, chemical and emotional stress that can accumulate and result in serious loss of health potential. Most time 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.

CHILDHOOD and ADOLESCENCE STRESSES

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.

Y / N Did you have any childhood illnesses?
Y / N Did you play youth sports?
Y / N Did you take/use recreational drugs?
Y / N Were you vaccinated?
Y / N Were you involved in any car accidents?
Y / N Were you under regular Chiropractic Care?
Y / N Did you have any serious falls as a child?
Y / N Have you fallen/jumped from a heights over 3 feet?
Y / N Was there prolonged use of antibiotics or inhaler?
Y / N Were teeth extracted or dental orthodontics used?
Y / N Did you suffer any physical or emotional traumas?

Family History

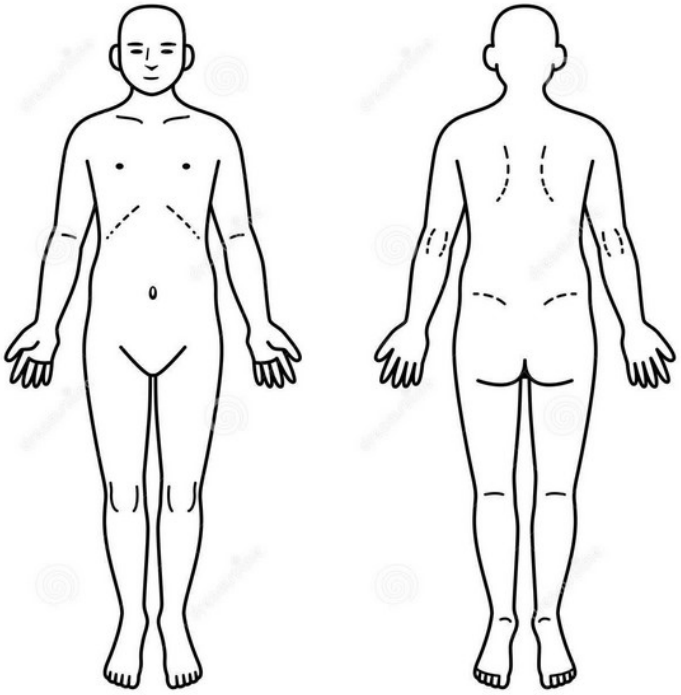
Our office attracts and cares for families. We are interested in how their health background may affect you, and your specific concerns. Please note any health concerns you have knowledge of.

Name	Relationship	Past & Present Health Problems
1.		
2.		
3.		
4.		

Your Current Concerns

If you have no complaints or symptoms, and are here for your wellness assessment, Please Check ____ and proceed to the next page.

Please describe the locations of your chief complaint using the key. Chiropractic assess the whole body so please indicate all areas of concern, even if you think they are unrelated to your chief concern. (Eg: Jaw discomfort, digestive discomfort, ear/balance trouble, wrist discomfort)



KEY

Please place letter of the key at your areas of concern.

A-ache
B-burning
N-numbness
P-pins/needles
S-stabbing

Reason for your visit? _____

When did this condition (s) begin? _____

Has it occurred before? _____

How frequent is the complaint? __Constant __Daily __Intermits __Nights Only __Other

Since it began, it is… __About the same __Getting better __Getting worse

What makes it worse? _____

How long does it last? __All Day __A few hours __Minutes Is it… __Mild __Moderate __Severe

Please rate you pain on the scale. No pain 0 1 2 3 4 5 6 7 8 9 10 Severe pain

Is the pain local? Y / N Does it go down your leg / arm? Y / N

What relieves the problem for you? (eg: rest, ice, heat, stretching, medication) _____

How has this impacted your life? _____

_____

_____

What have you had to give up because of this? _____

_____

TRAUMAS: Physical Injury History

Y / N Have you ever had any significant falls, surgeries or other injuries as an adult? If yes, please explain.

Y / N Any auto accidents? If yes, please explain.

Y / N Do you exercise? Frequency? _____ Type of exercise? _____

Y / N Have you ever been unconscious?

Y / N Do you commute to works? If yes, how many minutes per day? _____

How do you normally sleep? __Back __Side __Stomach Do you wake up: __Refreshed & Ready __Stiff & Tired

How many hours per day you typically spend sitting at a desk or on a computer, tablet or phone? _____

List any problems with flexibility: (ex: putting on shoes, socks, etc.)

TOXINS: Chemical & Environmental Exposure

Please rate your CONSUMPTION for each:

	None		Moderate		High		None		Moderate		High
Alcohol	1	2	3	4	5	Processed Foods	1	2	3	4	5
Water	1	2	3	4	5	Artificial Sweeteners	1	2	3	4	5
Sugar	1	2	3	4	5	Sugary Drinks	1	2	3	4	5
Dairy	1	2	3	4	5	Cigarettes	1	2	3	4	5
Gluten	1	2	3	4	5	Recreational Drugs	1	2	3	4	5

Please list any drugs/medication/supplements you take and why.
MEDICATIONS: __Pain __Blood Pressure __Blood Thinners __Blood Pressure __Heart __Anxiety

SUPPLEMENTS:

THOUGHTS: Emotional Stresses & Challenges

Please rate you stress for each:

	None		Moderate		High		None		Moderate		High
Home	1	2	3	4	5	Money	1	2	3	4	5
Work	1	2	3	4	5	Health	1	2	3	4	5
Life	1	2	3	4	5	Family	1	2	3	4	5

Your Current Health Goals

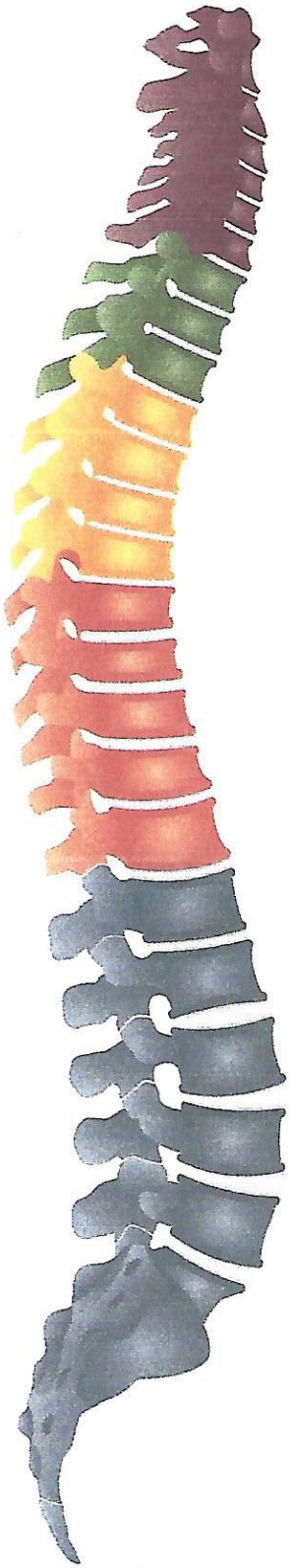
Please list your current health goals. **A C W**

1. _____
2. _____
3. _____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.



REGIONS	FUNCTIONS	SYMPTOMS			
		PAST	PRESENT	PAST	PRESENT
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐	☐ Colic & Excessive Crying	☐	☐ Epilepsy & Seizures
		☐	☐ Ear & Sinus Infections	☐	☐ Sensory & Spectrum
		☐	☐ Allergies & Congestion	☐	☐ ADD / ADHD
		☐	☐ Immune Deficiency	☐	☐ Focus & Memory Issues
		☐	☐ Headaches & Migraines	☐	☐ Anxiety & Stress
		☐	☐ Vertigo & Dizziness	☐	☐ Balance & Coordination
		☐	☐ Sore Throat & Strep	☐	☐ Speech Issues
		☐	☐ Swollen Tonsils & Adenoids	☐	☐ TMJ / Jaw Pain
		☐	☐ Vision & Hearing Issues	☐	☐ Stiff Neck & Shoulders
		☐	☐ Low Energy & Fatigue	☐	☐ Depression
		☐	☐ Difficulty Sleeping	☐	☐ High Blood Pressure
		☐	☐ Pain, Numbness & Tingling in Arms to Hands	☐	☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐	☐ Reflux / GERD	☐	☐ Bronchitis & Pneumonia
		☐	☐ Chronic Colds & Cough	☐	☐ Functional Heart Conditions
		☐	☐ Asthma		
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐	☐ Gallbladder Pain / Issues	☐	☐ Indigestion & Heartburn
		☐	☐ Jaundice	☐	☐ Stomach Pains & Ulcers
		☐	☐ Fever	☐	☐ Blood Sugar Problems
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐	☐ Behavior Issues	☐	☐ Allergies & Eczema
		☐	☐ Hyperactivity	☐	☐ Skin Conditions / Rash
		☐	☐ Chronic Fatigue	☐	☐ Kidney Problems
		☐	☐ Chronic Stress	☐	☐ Gas Pain & Bloating
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐	☐ Constipation	☐	☐ Sciatica & Radiating Pain
		☐	☐ Chrohn's, Colitis & IBS	☐	☐ Lumbopelvic / SI Joint Pain
		☐	☐ Diarrhea	☐	☐ Hamstring Tightness
		☐	☐ Bed-wetting	☐	☐ Disc Degeneration
		☐	☐ Bladder & Urination Issues	☐	☐ Leg Weakness & Cramps
		☐	☐ Cramps & Menstrual Issues	☐	☐ Poor Circulation & Cold Feet
		☐	☐ Cysts & Endometriosis	☐	☐ Knee, Ankle & Foot Pain
		☐	☐ Infertility	☐	☐ Weak Ankles & Arches
		☐	☐ Impotency	☐	☐ Lower Back Pain
		☐	☐ Hemorrhoids	☐	☐ Gluten & Casein Intolerance

Patient Name _____ Date _____

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