



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

## Family History

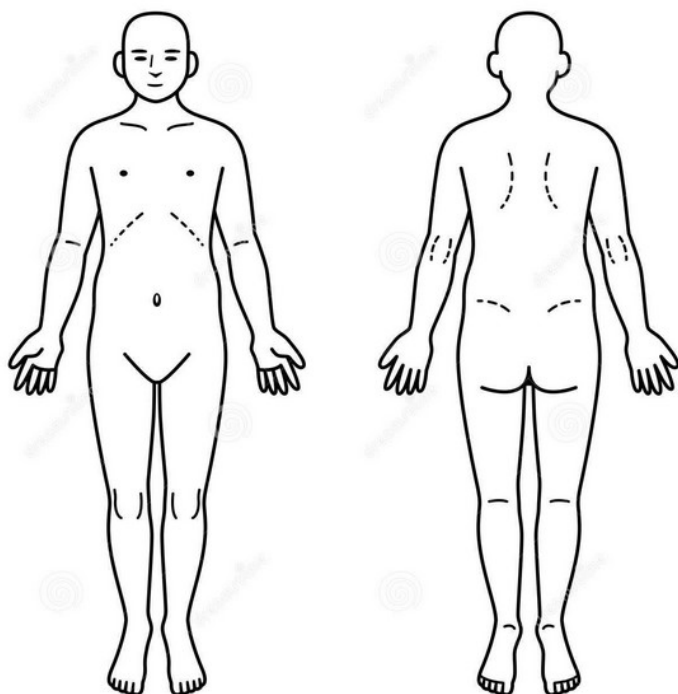
**Our office attracts and cares for families. We are interested in how their health background may affect you, and your specific concerns. Please note any health concerns you have knowledge of.**

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 your 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

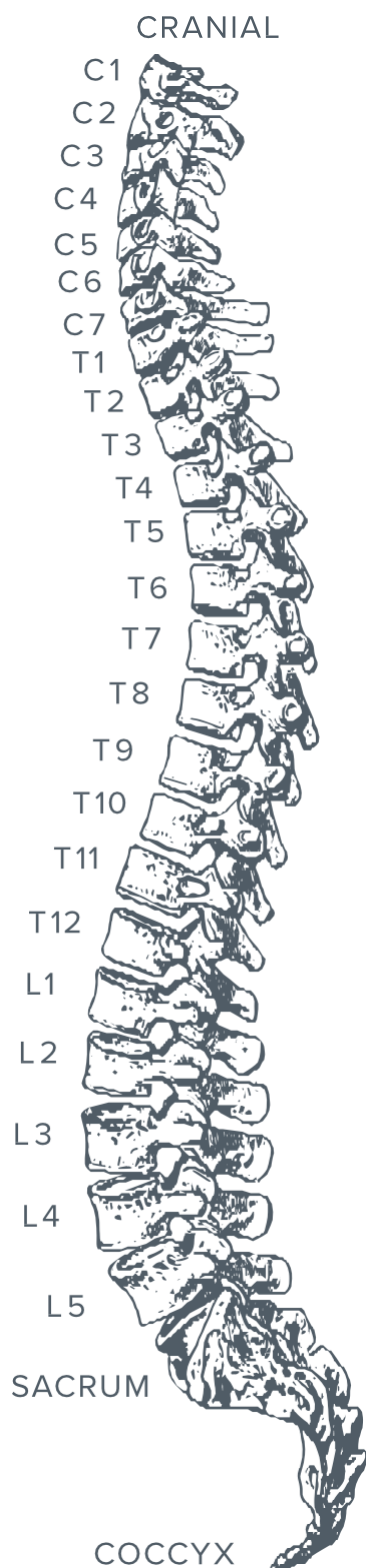
Please list your current health goals.

A C W

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

# BACK PROBLEM OR HEALTH PROBLEM?

Subluxations (nerve interference or damage) cause body & mind miscommunication, malfunction, and dis-ease



SPINAL LEVEL	BODY PAIN	INTERNAL ORGAN OR BODY MALFUNCTION	COMMON INTERNAL SYMPTOMS POTENTIALLY INDICATION MALFUNCTION OR DIS-EASE
Cranial C1, C2	Headache	All anatomical structures within the head; Brain, Cranial Nerves, Eyes, Ears, Nose, Throat, Sinuses, etc.	Spacey, dizzy, low energy, memory trouble, brain fog, ADD, ADHD, ear aches, tinnitus, nose bleeds, sinus problems, snoring, sleep disorders, sore throats, colds, flus, itchy & achy eyes, allergies, food sensitivity
C3	Neck	Diaphragm	Difficult to take deep breath, chronic fatigue, anxiety, vertigo, shortness of breath, allergies
C4	Neck	Thyroid	Low = weight gain, feelings of being cold High = insomnia, nervousness, swollen glands
C5	Shoulder	Sugar Handling Function	Craving sweets, tired after eating, headaches if too long between meals, emotional, heart palpitations
C6	Arm	Stomach	Stomach pains after eating, needs antacids
C7	Hand	Liver	Sluggishness, sneezing, nightmares, burning feet, allergies
T1, T2	Finger	Heart	Coronary artery disease, functional heart conditions, high or low blood pressure, chest pain
T3		Lungs & Bronchi	Asthma, shortness of breath, chronic coughs, allergies
T4	Upper Back	Gall Bladder	Heartburn, bloating after meals, gassy, burping, trouble with fatty foods
T5		Stomach	Heartburn, indigestion, stomach troubles, ulcers
T6		Pancreas	Craving sweets, tired after eating, headaches if too long between meals, emotional, heart palpitations, indigestion
	Mid Back	Spleen & Immune Function	Lowered Resistance, immune deficiencies, frequent colds or flus, allergies
T8		Liver	Headaches, low energy, sneezing, nightmares, burning feet
T9		Adrenal Glands	Overwhelmed by stress, allergies
T10		Small Intestine	Digestive complaints: 1-2 hours after eating
T11, T12		Kidneys & Bladder	Decreased urine output, swollen ankles, puffy eyelids, kidney or bladder infections, high or low blood pressure
	Low Back	Ileocecal Valve	Sciatica, bad breath, flatulence, headaches when sleeping too long, dark circles under eyes, toxicity, allergies
	Hip	Cecum	Sciatica, digestive complaints: 1-2 hours after eating, abdominal cramps, allergies
	Leg	Endocrine Glands: Thyroid, Pancreas, Liver, Adrenals	See organs' primary subluxation sites: C4, C5, C7, T6, T8
	Knee, Ankle	Colon, Prostate or Uterus	Sciatica, bowel problems, coated tongue, headaches, allergies, hemorrhoids, varicose veins, prostate problems, impotence, painful periods, PMS, menopause symptoms
Sacrum	Foot	Reproductive Organs	Sciatica, reproductive disorders
Coccyx	Toe	Overall tone of the nervous system	Sciatica, chronic depression, migraines, vertigo, dyslexia, epilepsy, ADD, ADHD, compulsive disorders, sensitivity to light, PMS, painful periods, menopause symptoms, impotence

## CHIROPRACTIC PREMISE

1. Your nervous system (brain, spinal cord and nerves) controls and coordinates **everything** in your body and mind.
2. When your nerve energy flows abundantly without obstruction, your body and mind are 100% self-communicating, self-healing, and self-regulating and robust.
3. When subluxations (nerve interference or damage) impede nerve flow, similar to static on your cell phone, you are no longer functioning at 100% and your health and vitality are compromised.
4. Subluxations are caused by our inability to handle life's three major stressors; physical, mental-emotional and chemical.
5. Left uncorrected, subluxations have devastating effects upon human health and well-being, leading to breakdown, malfunction and dis-ease.
6. Our goal is to locate subluxations, remove them and their causes and allow you to heal yourself on every level.
7. Only chiropractors can determine if you have subluxations. WHO DO YOU KNOW THAT NEEDS TO BE CHECKED?

**Adjustments correct subluxations so your body can heal and function at higher levels.**

**PATIENTS NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

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REFERENCES: Fix, J.D., Ph.D., *Neuroanatomy*, 3rd Edition, Lippincott Williams & Wilkins, 2002; Kandel, E.R., Schwartz, J.H., Jessell, T.M., *Principles of Neural Science*, Appleton & Lange, 1991; Hoppenfield, S.M.D., *Physical Examination of the Spine and Extremities*, Appleton-Century-Crofts, 1976; Netter, F.H. M.D., *The CIBA Collection of Medical Illustrations*, Vol 1, Nervous System, Part 1, Anatomy and Physiology, Ciba Pharmaceuticals Division, Ciba-Geigy Corp, 1991. \*This chart has been simplified for demonstration purposes. It does not illustrate all intricate nerve pathways. The symptoms listed are a guide to potential effects of subluxations. \*Special thanks and recognition to Dr. Gururang Singh Khalsa in the creation of this chart. ©TheOHCSystem, Inc. (808) 878-8384 - TheOHCSystem.com