JOY of LIVING CHIROPRACTIC

New Practice Member Health Profile

Name: _____ DOB (mm/dd/year):_____ Age: _____ Male / Female

Address: _____ City: _____ Province: ____ Postal Code: _____

Email: _____ Extended Health Care: Yes / No Provider: _____

Phone: Home (____) ____-____ Cell (____) -____-_____ Cell Provider: _____

Occupation: _____ Employer: _____

Status: Single / Common Law / Married / Divorced / Widowed

Spouse's Name: _____ Number of Children: _____

If provided, email will only be used for appointment reminders, newsletters, event invites, and pertinent office information, as per the requirements of Canada's anti-spam legislation.

Names, Ages, Gender: _____ Have they had a spine check-up? Yes / No

Emergency Contact: _____ Relationship: _____

Who may we thank for referring you? _____

Health Concerns

	Health Concerns: List according to severity. ↓	Pain Intensity 0 = No Pain 10 = Worst Pain Imaginable ↓	When did this begin? ↓	How did this begin? ↓	Have you had this problem before? If so, when? ↓	Are symptoms constant (C), Intermittent (I), or Other. ↓	Type of Pain *↓
1.	_____	_____	_____	_____	_____	_____	___
2.	_____	_____	_____	_____	_____	_____	___
3.	_____	_____	_____	_____	_____	_____	___
4.	_____	_____	_____	_____	_____	_____	___

* For "type of pain", refer to this legend and use the corresponding letter(s):
S = **S**harp/**S**tabbing, **T** = **T**hrobbing, **Ti** = **Ti**ngling, **D** = **D**ull, **St** = **St**iffness, **Sp** = **Sp**asm, **B** = **B**urning, **A** = **A**che, **W** = **W**eakness, **N** = **N**umbness, **Sh** = Shooting

Does the pain travel? (i.e. down leg(s) / into fingers) _____

What relieves your symptoms? _____

What makes your symptoms worse? _____

When are your symptoms the worst? (i.e. morning / night) _____

Have you seen other providers for these concerns? Yes / No If Yes : Who?
Chiropractor: _____ Medical Doctor: _____ Other: _____
Results: _____

How do your health concerns interfere with your daily living? (i.e. sleep, walking, hobbies, chores, work, exercise, sitting, standing, self-care, sports, leisure, etc) _____

_____

When was your last complete chiropractic evaluation? Date: _____

Previous Chiropractor: _____ Were x-rays taken? Yes / No Date: _____

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

___ ADHD	___ Difficulty Breathing	___High/Low Blood Pressure	___ Migraines	___ Sexual Dysfunction
___ Allergies	___ Digestive Issues	___ Hip/Leg Pain	___ Nausea	___ Shoulder Pain
___ Anxiety	___ Disc Problems	___ Infertility	___ Neck Pain	___ Sinus Issues
___ Arm Pain	___ Dizziness	___ Insomnia	___ Nervousness	___ Skin Problems
___ Arthritis /Joint Pain	___ Double/Blurry Vision	___ Jaw/TMJ Pain	___ Numb/Tingling in Arms/Hands	___ Sleep Apnea
___ Asthma	___ Ear Infections	___ Kidney Problems	___ Numb/Tingling in Legs/Feet	___ Sports Injury
___ Autism	___ Epilepsy/ Convulsions	___ Knee Pain	___ Poor Posture	___ Stomach Problems
___ Autoimmune Issues	___ Fibromyalgia	___ Loss of Balance	___ Prostate Problems	___ Thyroid Issues
___ Bed Wetting	___ Foot Pain	___ Loss of Energy	___ Ringing in the Ears	___ Tight/Sore Muscles
___ Bladder Problems	___ Frequent Colds	___ Low Back Pain	___ Sciatica	___ Tremors
___ Chest Pain	___ GERD/Gastric Reflux	___ Memory Loss	___ Scoliosis	___ Ulcers
___ Constipation	___ Headaches	___ Menstrual Problems	___ Seizures	___ Upper Back Pain
___ Depression	___ Hearing Loss	___ Mid Back Pain		
___ Diarrhea	___ Heart Problems			

Others: _____

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

___ Brain Injury	___ Concussion	___ Dislocations	___ Scoliosis	___ Tumors
___ Cancer	___ Diabetes	___ Heart Attack	___ Spinal Fracture	___ Other Serious Condition: _____
___ Cerebral Vascular Event	___ Disability	___ Rheumatoid Arthritis	___ Spinal Surgery	

List all surgical operations & years: _____

List any other injuries, minor or major: _____

List all over the counter, prescription medications, & supplements you are on, & the reason for each:

_____

Have you ever been in a car accident? List all: _____

Social History: Do you:

Smoke/Vape/Use Tobacco or Nicotine Products: Yes / No if yes, How often: _____ Quantity: _____
Consume Alcohol: Yes / No if yes, How often: _____ Quantity: _____
Consume Coffee, Tea, Soft Drinks: Yes / No if yes, How often: _____ Quantity: _____
Exercise: Yes / No if yes, How often: _____ Quantity: _____

Are there any other physical, chemical, or emotional stresses that you think may be affecting you in any way?

_____

I would like to experience the following benefits from chiropractic care:

□ Symptomatic relief □ Correction of the cause of the problem as well as relief □ Prevention of future problems

□ Healthier spine and nervous system □ Optimal health on all levels □ Other: _____

Women: Spinal health is especially important during pregnancy. Is there a possibility you may be pregnant?

Yes / No / Maybe / Trying Date of last menstrual period: _____

Name: _____ Signature: _____ Date: _____

Family Health Profile

This form is to assist the doctors by providing family health history information for their review.

Please Mark "P" For In The Past OR Mark "C" For Currently Have:

	Spouse	Children	Mother	Father
Abnormal Posture				
Acid Reflux				
ADHD				
Allergies				
Alzheimer's				
Anxiety/Nervousness				
Arthritis/Joint Pain				
Asthma/Breathing Difficulties				
Autism Spectrum Disorder				
Autoimmune Disorders				
Back Pain				
Bed Wetting				
Blurred/Double Vision				
Cancer				
Carpal Tunnel				
Depression				
Diabetes				
Digestive/Stomach Problems				
Disc Problems				
Dizziness				
Ear Infections				
Fatigue				
Fibromyalgia				
Frequent Colds/Illness				
Headaches				
Hearing Issues				
Heart Problems				
High/Low Blood Pressure				
Hip/Leg Pain				
Infertility				
Jaw/TMJ Pain				
Kidney Condition				
Menstrual Problems				
Migraines				
Neck Pain				
Numbness/Tingling				
Poor Posture				
Sciatica				
Scoliosis				
Shoulder Pain				
Sinus Issues				
Sleeping Difficulties				
Stiffness				
Stroke				
Thyroid Problems				
Ulcers				