Please describe your health from *childhood* up to age 17.

Research is showing that most health challenges, that occur later in life, have their origins during the developmental years, some starting at birth.

Please answer and comment on the following questions to the best of your ability.

☐ Yes ☐ No Did you have any childhood illnesses or allergies? (Explain)

☐ Yes ☐ No Did you have any serious falls as a child? (Explain)

☐ Yes ☐ No Did you play youth sports? (Explain)

☐ Yes ☐ No Did you take/use any drugs? (Explain)

☐ Yes ☐ No Did you have any surgery? (Explain)

☐ Yes ☐ No Have you fallen or jumped from a height over three feet? (Explain)

☐ Yes ☐ No Were you involved in any car accidents as a child? (Explain)

☐ Yes ☐ No Did you suffer any other traumas, emotional, physical or toxic? (Explain)

☐ Yes ☐ No Was there any prolonged use of medicine (i.e. antibiotics, inhalers, Ritalin?) (Explain)

☐ Yes ☐ No Were you vaccinated? (Explain)

☐ Yes ☐ No Were you under regular chiropractic care? (with whom and for how long?)

Were you born: ☐ Naturally, ☐ C-section, ☐ Forceps, ☐ Vacuum, ☐ Labour induced, ☐ Unsure (Explain)

On your Mother's side is there a history of : ☐ Heart Desease, ☐ Stroke, ☐ Cancer, ☐ Arthritis, ☐ Diabetes, ☐ Other

On your Father's side is there a history of : ☐ Heart Desease, ☐ Stroke, ☐ Cancer, ☐ Arthritis, ☐ Diabetes, ☐ Other

Why Chiropractic Care?

Release Care - People visit a Chiropractor for a variety of reasons. Some go for symptomatic relief of a disease, condition or infirmity.

Rebuild Care - Others are interested in having the CAUSE of the problem as well as the symptoms corrected.

Revitalize Care - Still others want whatever is malfunctioning in their bodies brought to the highest state of health potential.

How long you choose to benefit from Chiropractic Care is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ **Release Care** (relief only)

☐ **Rebuild Care** (removing & correct cause)

☐ **Revitalize Care** (pursuit of optimal health)

☐ Let the doctor select the most appropriate type for me.

Please rate your level of commitment to resolving this/these problem(s) (10 being the highest)

1 2 3 4 5 6 7 8 9 10

Patient signature: Today's Date

Welcome to Meyer Chiropractic Health Centre

MEYER CHIROPRACTIC HEALTH CENTRE

Confidential Adult Patient Health Record

Confidential Personal Information

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address 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 the physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. 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 access the challenges to your current health situation.

First Name: Last Name:

Address: City: Postal Code:

Email Address: Home Telephone: Work Telephone: Cell Telephone:

Date of Birth: ☐ Male ☐ Female

☐ Married Name of Spouse: ☐ Single ☐ Divorced ☐ Widowed

Number of children and names:

Whom should we thank for referring you to our office? Name of Medical Doctor: Address:

Describe your symptoms or complaints.

What is the main issue you would like my help with? (Explain)

Why do **you** think you have this problem? (Explain)

How long have you had this problem? (Explain)

If you are experiencing pain (body signals) is it: ☐ sharp, ☐ dull, ☐ throbbing, ☐ achy, ☐ burning, ☐ comes and goes, ☐ constant, ☐ travels (To where): (Explain)

Please rate the level of severity of your pain:

None	Mild Discomfort	Distress	Horrible	Excruciating
1 2	3 4	5 6	7 8	9 10

(Explain)

Since the issue started is it: ☐ about the same, ☐ getting worse, ☐ getting better (Explain)

What makes it worse: (Explain) | Better: (Explain)

This issue affects my ability to: be/do/have? (Explain)

Does the issue interfere with: ☐ sleep, ☐ work, ☐ family life, ☐ walking, ☐ sitting, ☐ hobbies, ☐ leisure, ☐ exercise, ☐ routine (Explain in detail)

Health Goals

1. What are your immediate health goals:

2. What are your future health goals:

3. If you could have ultimate health you would be able to:

Names of other doctors seen for this issue:

Chiropractor: | Results:

Other Health Practitioner: | Results:

☐ Yes ☐ No Were any X-Rays taken?: (When and of what) (Explain)

Other Tests: (Explain) | Results: (Explain)

Meyer Chiropractic Health Centre | 275 Trafalgar Road, Second Floor, Oakville ON L6J 3H1

Describe your health <u>from age 18 to the present day</u>.

Please answer and comment on the following questions to the best of your ability.

☐ Yes ☐ No Do/did you smoke? How much per day? (Explain)

☐ Yes ☐ No Do/did you drink alcohol? How much in a typical week? (Explain)

☐ Yes ☐ No Do you take over the counter or prescription medicines? What and how much? (Explain)

☐ Yes ☐ No Did you suffer any traumas, emotional, physical or toxic?

☐ Yes ☐ No Have you been in any accidents? When and what? (Explain)

☐ Yes ☐ No Was your nervous system checked by a chiropractor? (Explain)

☐ Yes ☐ No Have you had any surgery, What and when. (Explain)

How much water do you drink daily? (cups or ounces)

How much coffee or regular tea do you drink daily? (cups)

How many juices or pops do you drink daily? (cups, cans or bottles)

☐ Yes ☐ No What supplements do you take regularly? (Name them)

How would you describe your diet? ☐ Horrible ☐ Poor ☐ Fair ☐ Good ☐ Stellar

☐ Yes ☐ No Do/did you participate in extreme or contact sports? (Explain)

Rate your stress level on a scale of 1-10 (1 none, 10 severe)

Occupational stress: 1 2 3 4 5 6 7 8 9 10 (Describe why)

Personal stress 1 2 3 4 5 6 7 8 9 10 (Describe why)

☐ Yes ☐ No Do you follow a REGULAR exercise program? What and how often? (Explain)

Do you sleep well? ☐ Yes ☐ No. How many hours per night? (Hr.) Do you feel rested upon waking? ☐ Yes ☐ No

What type of pillow do you use? ☐ Contour (neck pillow) ☐ feather ☐ foam ☐ water pillow

What position do you sleep in? ☐ side ☐ back ☐ stomach ☐ all over the place

During my day I mostly: ☐ sit ☐ stand ☐ walk ☐ drive ☐ on the phone ☐ computer ☐ other

Please check-off any of the following symptoms you have had in the past or are experiencing now, even if you do not think they are related to the current problem.

Past	Now		Past	Now		Past	Now	
☐	☐	Stress	☐	☐	Pinched nerve	☐	☐	Diarrhea/ ☐ constipation
☐	☐	Loss of sleep	☐	☐	Chronic infections	☐	☐	Thyroid issues
☐	☐	Dizziness	☐	☐	Low back/ ☐ hip pain	☐	☐	Upset stomach
☐	☐	Fatigue	☐	☐	Walking problems	☐	☐	Mood swings
☐	☐	Confusion/forgetfulness	☐	☐	Decreased immunity/ ☐ frequent colds	☐	☐	Liver problems
☐	☐	Imbalance				☐	☐	Gall bladder problems
☐	☐	Headaches	☐	☐	Asthma/ ☐ allergies	☐	☐	Osteoporosis/ ☐ osteopenia
☐	☐	Migraines	☐	☐	Shortness of breath	☐	☐	Bladder trouble/ ☐ painful or frequent urination
☐	☐	Neck / ☐ arm / ☐ shoulder pain	☐	☐	Heart/vascular problems			
☐	☐	Leg / ☐ knee / ☐ foot pain	☐	☐	Chest/breast pains	☐	☐	Sexual dysfunction
☐	☐	Arthritis	☐	☐	Buzzing/ringing in the ears	☐	☐	Blood pressure trouble
☐	☐	Herniated disc	☐	☐	Frequent nausea	☐	☐	Ankle swelling
☐	☐	Numbness/ ☐ tingling	☐	☐	Ulcers/heartburn	☐	☐	Cancer of:
☐	☐	Depression	☐	☐	Diabetes	.....		
☐	☐	Pain between shoulders	☐	☐	Pain/stiff in the mornings	.....		

For Women Only:

Past	Now	
☐	☐	Miscarriage(s)
☐	☐	Menstrual irregularity
☐	☐	Menstrual cramps
☐	☐	Mood swings

Are you Pregnant?

☐ No
☐ Yes
☐ Trying
☐ Unsure

Date of last menstrual cycle:

.....

See over →