



First Name _____ Initial _____ Last Name _____
 Address _____ Apartment _____ Unit# _____
 City _____ Province _____ Postal Code _____
 Who Referred You To Our Clinic? _____
 Date of Birth (dd/mm/yy) _____ Male _____ Female _____
 Phone: Home _____ Work _____ Cell/Pager _____
 Email Address _____

WHY THIS FORM IS IMPORTANT

Our office focuses on maximizing health. Our goals are to 1) address the issue that brought you to this office and 2) to offer the opportunity to learn and improve your health potential for the future. Daily activities/stresses/traumas can accumulate and cause damage to your nervous system. This damage builds layer upon layer to a level at which you may not yet be aware. We need to know what your layers of damage contain, so we ask you to carefully fill out this detailed and important form.

Research is showing that many of the health challenges that occur later in life originate during the developmental (early) years of our lives. That's why many parents bring their children in for regular spinal check-ups so that they can be as healthy as possible and prevent future problems. Please be specific as you can with your answers.

THE BEGINNING YEARS OF LIFE (Birth to Age 15)	YES	NO	<u>EXPLAIN/COMMENTS:</u>
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you fallen/jumped from a height Over three feet? (crib/bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there any prolonged use of medicine, such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any other traumas? (physical or emotional)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you Vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you under regular chiropractic care as a child?	<input type="checkbox"/>	<input type="checkbox"/>	_____

YOUNG ADULT (Age 15 to Present)	YES	NO	<u>EXPLAIN/COMMENTS:</u>
Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____

On a scale of 1-10 describe your stress level at Work _____ Personal Life _____ (0=None 10=Extreme)
 On a scale of Poor, Good, Excellent describe your: Exercise _____ Sleep _____ Diet _____
 Have you ever been to a Doctor of Chiropractic before? YES NO
 Who? _____ Date of Last Visit _____
 For what reason? _____



People who have already experienced **Chiropractic Wellness Care** and are here to continue, need only check the box: **"I Wish to continue my Chiropractic Maintenance"** .

Others need to please complete the following:

Your Main Complaint:

On a scale of 1 to 10, with **10 being the highest**, rate your commitment in helping us solve your problem:

1 2 3 4 5 6 7 8 9 10

Any other Complaints: _____

How long have you suffered with the **main** complaint? _____

What is the pattern of this problem? Constant Intermittent Occasional Cyclic

How did it start? _____

Could your problem have been caused by an injury at work? YES NO

If yes, please give us the details incl. date and how injury happened: _____

Have you had previous treatment for your main complaint? YES NO

If yes list treatment: _____

What gives you some temporary relief? _____

What do you do that makes this problem worse? _____

When your problem is at its worst, how does it make you feel? _____

What have you tried to do to get rid of this problem that **DID NOT** work? _____

Have you become discouraged about handling this problem? YES NO

Does experiencing this problem cause stress for you? YES NO

How much older does this make you feel: _____

Which of the following areas of your life does your problem affect?

WORK: Explain: _____

FAMILY: Explain: _____

HOBBIES: Explain: _____

LIFE: Explain: _____

What of the following activities does your problem prevent you from doing, either partially or totally?

Sleep Walking Sitting Leisure Work (What is your job? _____)

Explain: _____

What effect does your problem have on your bodily functions? _____

Have you been involved in an auto accident? YES NO

If Yes indicated the date and details: _____

Do you have any children? YES NO; If yes how many _____ List their ages: _____

Do they have any health conditions that you are aware of? YES NO

If yes, what are they? _____

Health conditions of immediate family members: _____



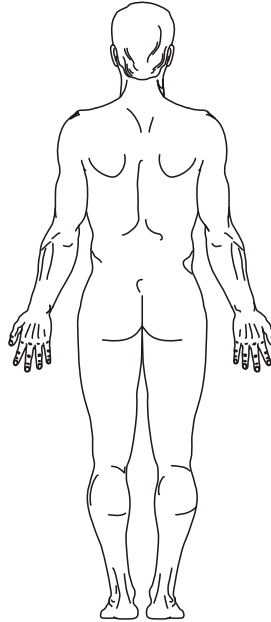
Location of Pain:

Please use the following chart to **draw the letter "X"** in the areas that bother you. Next to each of these areas, use the appropriate letter to describe what you feel. (Example: If your hand is numb, draw an "X" in the hand and put "N" next to the hand for numbness).

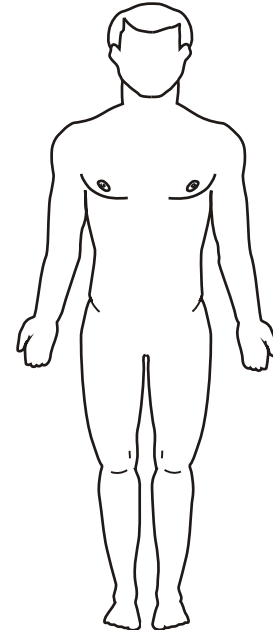
Legend:

- N** numbness
- P** pain
- T** tingling
- A** ache
- S** soreness
- ST** stiffness

Back



Front



The following symptoms are signs of **nervous system problems**. Please check off all that you presently have or have had in the past even if they do not seem to be related to your current problem.

O = Occasional **F** = Frequent **C** = Constant

- | | | |
|---|---|---|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of smell | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pins & Needles in arms | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Visual problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menstrual pain |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Problems Urinating | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cold hands | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck Pain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cold feet | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Back Pain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds/sickness |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irritability | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of balance | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heart Burn | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergies |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ulcers | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sweating |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of taste | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stomach Tension | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting |

Do you suffer from any of the following?:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Heart condition / Angina | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Intestinal tract disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tendonitis / Bursitis | <input type="checkbox"/> Hormonal imbalances | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Prostate Condition | <input type="checkbox"/> Spinal Disc Problems | <input type="checkbox"/> PMS | <input type="checkbox"/> Bloating after meals |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Weak Immune System | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Eczema / Psoriasis |



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What, if any, surgeries have you ever had? _____
Have you ever been diagnosed with any diseases? _____
Have you lost more than 20 lbs in the past 90 days? Yes No
Who is your family Doctor? _____ Phone: _____
Please list any medications that you are currently taking: (including aspirin, Tylenol, antihistamines, birth control pills, HRT, etc...) _____

Do you utilize other forms of Holistic health care methods? (Massage Therapy, Naturopathy, Yoga, Acupuncture, Vitamins, Herbs...) _____

What Vitamins / Herbs do you take? Please list _____

Do you sleep with a special cervical pillow? Yes No

Do you use orthotic shoe devices? Yes No

Is there any other information you would like us to know?

For Women Only

Date of your last menstrual period: _____

Are you pregnant? Yes No

Are using any means of contraception? _____

Do you experience severe cramping with your menstrual period? Yes No

Do you suffer from PMS? Yes No

Have you ever miscarried? Yes No

For All Patients

SIGNATURE: _____ DATE: _____

PLEASE BRING THESE FORMS COMPLETED TO OUR OFFICE ON THE DAY OF YOUR APPOINTMENT

Thank You!