Appleview Chiropractic Clinic
686 Appleby Line, Unit C3, Burlington ON L7L 5Y3
Phone: 905-639-0073 email: appleviewchiro@gmail.com

PERSONAL HEALTH PROFILE

Date:	First Name:	Last Name:	
Home Address:		City:	Postal Code:
Primary Email Address:		Alternative Email Address:	
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	

Gender: ☐M ☐F	Date of Birth: DD: MM: YY:	Age:	Height: feet, Inches	Weight: Pounds	Family Physician Name: Phone: Date of last visit:
Marital Status: ☐ Single ☐ Married ☐ Common law ☐ Widowed ☐ Separated ☐ Divorced					Occupation:
Spouse/Partner's Name:					Employer:
Spouse/Partner's Cell Phone:					Extended Health Insurance (EHI): ☐ No ☐ Yes Company:
Do you have children? ☐ No ☐ Yes What are your children's names/ages?					EHI $ Participation / Year: Is this amount ☐ per person or ☐ for the entire family? EHI Renewal Date:
If you are under 18, what are your Parents' names?					Which patient referred you to our office? Other referral source:

Present State of Health

Years of continuing nerve and spinal damage show up as acute or chronic symptoms.

	Primary concern	Secondary concern
Specific concern(s) and location		
How long have you had this?		
How would you describe the concern?	❒ Sharp ❒ Dull/achy ❒ Burn ❒ Pins/needles	❒ Sharp ❒ Dull/achy ❒ Burn ❒ Pins/needles
How often does this happen?	❒ Constant ❒ Intermittent ❒ Daily ❒ Weekly ❒ Monthly ❒ _____	❒ Constant ❒ Intermittent ❒ Daily ❒ Weekly ❒ Monthly ❒ _____
What makes it worse? (sitting, standing etc)		
What have you tried to address this concern?		
At its worst, this problem interferes with:	❒ Ability to work ❒ Hobbies/sports ❒ Family/social time ❒ Sleep ❒ Daily activities ❒ Other_____	❒ Ability to work ❒ Hobbies/sports ❒ Family/social time ❒ Sleep ❒ Daily activities ❒ Other_____
If you don't get your problems corrected do you think it will get worse in the next ❒ 1 year ❒ 2 years ❒ 5 years		

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Have you ever received chiropractic care before? ☐ No ☐ Yes – Complete Table below

Who was the Doctor?	Years under Care?	How often did you go? ☐ 3x/week ☐ 2x/week ☐ 1x/week ☐ Biweekly ☐ Monthly ☐ Whenever in pain ☐ Other_____	
When was your last visit?	Were X-Rays taken? ☐ Yes ☐ No	Were Follow up X-Rays taken? ☐ Yes ☐ No	Date of last X-Ray

What did you like the MOST about your previous experience with your Doctor of Chiropractic/Medical Doctor?

_____

What did you like the LEAST about your previous experience with your Doctor of Chiropractic/Medical Doctor?

_____

Health History

Trauma and Stresses	Office Use
Automobile Accident(s) - Only 10km/h is needed to cause nerve and spinal damage. 1. Date:_____ ☐ Driver ☐ Passenger Impact Speed_____km/h, Site of Impact ☐ Front End ☐ Read End ☐ Side Swipe ☐ T-Bone What impacted the car? ☐ Car(s) ☐ Person ☐ Other_____ Symptoms_____ ☐ Seatbelt ☐ Air Bag Deployed Spine checked by Chiropractor after accident ☐ Yes ☐ No 2. Date:_____ ☐ Driver ☐ Passenger Impact Speed_____km/h, Site of Impact ☐ Front End ☐ Read End ☐ Side Swipe ☐ T-Bone What impacted the car? ☐ Car(s) ☐ Person ☐ Other_____ Symptoms_____ ☐ Seatbelt ☐ Air Bag Deployed Spine checked by Chiropractor after accident ☐ Yes ☐ No	
Have you fractured any bones in your body? Which bones and when?	
Falls, Impacts, Injuries from Work and Home:	
Falls, Impacts, Injuries from Hobbies and Sports:	
How many hours per day do you spend: Sitting at work_____ Standing at work_____ Lifting/Carrying _____ Year(s) at job with similar postures (sitting, standing, lifting)	
How many hours per day do you use the following: Computer _____ Smart Phone _____ Tablet _____	
How many hours per day do you spend: Sitting at home_____ Standing at home_____	
On average, how many hours do you sleep per night?_____ Do you sleep on your ☐ Back ☐ Side ☐ Front? (Check all that apply) ☐ Difficulty falling asleep ☐ Difficulty staying asleep How many times do you wake up per night_____	
Child birth has been proven to be traumatic to the spine and nervous system. How was your birth? ☐ Long and/or difficult ☐ Forceps ☐ Vacuum extraction ☐ Caesarean ☐ Breech ☐ Epidural ☐ Induced ☐ Vaginal ☐ Natural (no drugs or pulling/excessive force) ☐ Don't know?	

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Have you ever been hospitalized? If so, please describe:

What surgeries have you had? (type and date)

What medications have you taken in the last 5 years?
❒ Blood Pressure ❒ Cholesterol ❒ Pain Killers ❒ Antidepressants ❒ Antihistamines ❒ Inhaler
❒ Other _____

What chemicals/toxins have you been exposed to:
❒ Alcohol ❒ Tobacco (First or Secondhand) ❒ Marijuana ❒ Work/Home Pollution_____
❒ Mercury Tooth Fillings ❒ Other_____

Rate your mental/emotional stress level from 0 to 10 on the scale below:

No Stress Moderate Stress High Stress

0 1 2 3 4 5 6 7 8 9 10

What is causing your stress ❒ Work ❒ Home ❒ Family ❒ Other_____

Family Health History

Many health concerns are related through family members. What health concerns has your family experienced?

Children: _____ Spouse/Partner: _____ Parents: _____
_____ _____ _____
_____ _____ _____

What are the most important reasons you want better health? _____

_____

On a scale of 1 to 10 (10 being the highest), rate your **commitment** to achieve the reasons listed above.

(Circle number): 1 2 3 4 5 6 7 8 9 10

Not committed at all — Somewhat committed — Highly committed

If your commitment is not a 10, what is holding you back from being a 10? _____

_____

For Doctors Use

Verbal Consent Given for Exam_____

Balance (kg) L / R / Even	Cervical Rot. Left (80)	Cervical Rot. Right (80)	Cervical Flexion (65)	Cervical Ext. (50)	Cervical Lat. Flex Left (45)	Cervical Lat. Flex. Rt. (45)	Lumbar Flex. (90)	Lumbar Ext. (30)	Other	Other

Palpation

OC	C1	C2	C3	C4	C5	C6	C7	T1	T2	T3	T4	T5	T6	T7	T8	T9	T 10	T 11	T 12	L1	L2	L3	L4	L5	S X	L SI	R SI	C X

Other

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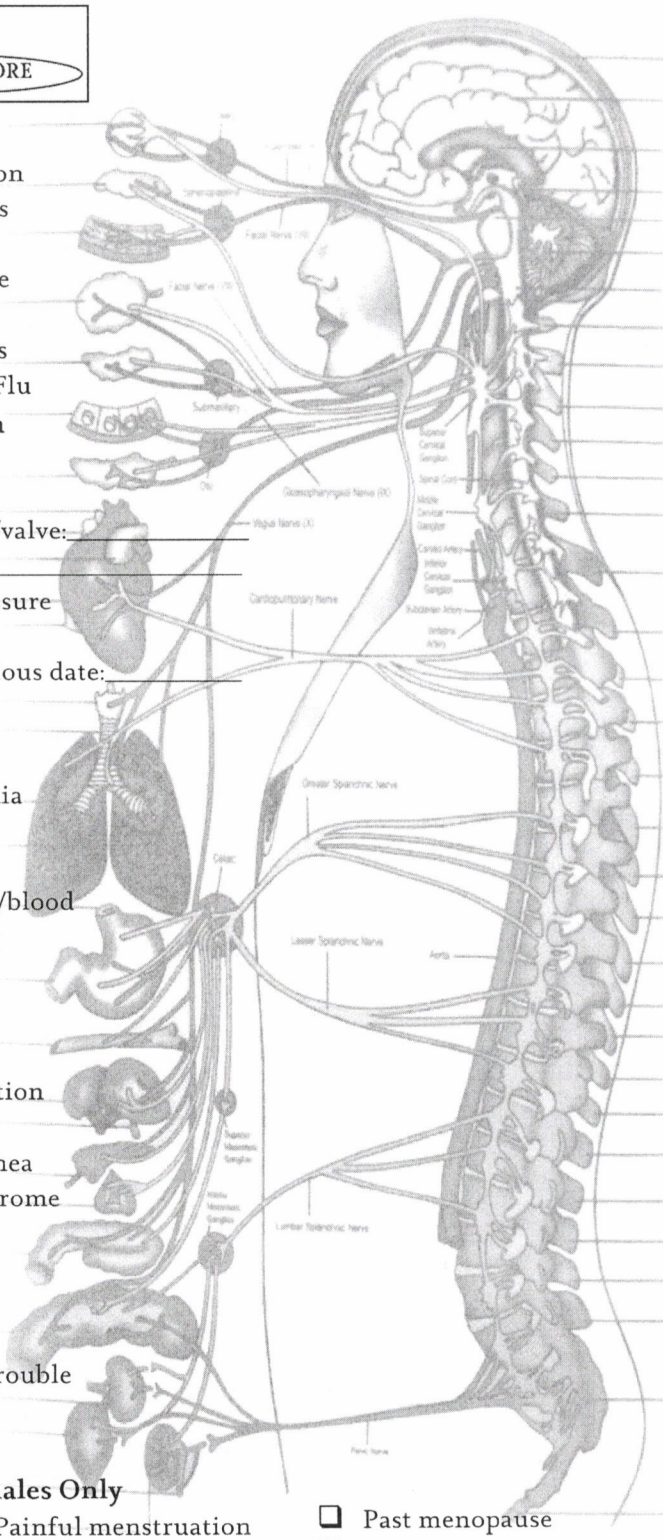
Health Concerns

Please check/circle any of the following signs of organ malfunction or dis-ease you have experienced

☑ CURRENT
EXPERIENCED BEFORE



Immune System
- ❑ Earaches/ear infection
- ❑ Sore throat/tonsilitis
- ❑ Sinus problems
- ❑ Autoimmune disease
- ❑ Antibiotic use
- ❑ Fever / chills / sweats
- ❑ Frequent colds and Flu

Cardiovascular System
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Irregular heart beat/valve:_____
- ❑ Heart medication: _____
- ❑ High/low blood pressure
- ❑ Swelling of legs
- ❑ Heart Attack – Previous date:_____

Respiratory System
- ❑ Frequent bronchitis
- ❑ History of pneumonia
- ❑ Asthma/allergies
- ❑ Chronic cough
- ❑ Spitting up phlegm /blood
- ❑ Difficulty breathing
- ❑ Tuberculosis
- ❑ Pneumonia

Digestive System
- ❑ Heartburn / indigestion
- ❑ Stomach cramps
- ❑ Constipation /diarrhea
- ❑ Irritable bowel syndrome
- ❑ Crohn's disease
- ❑ Ulcers
- ❑ Belching /gas
- ❑ Nausea or vomiting
- ❑ Liver /gall bladder trouble
- ❑ Colon trouble
- ❑ Black /bloody stool
- ❑ Diabetes

General Symptoms
- ❑ Dizziness
- ❑ Blurred /failing vision
- ❑ Deafness /ringing in ears
- ❑ Thyroid problems
- ❑ Fainting / dizziness
- ❑ Seizures / convulsions
- ❑ Skin problems
- ❑ Tremors
- ❑ Loss of balance
- ❑ Unexplained weight loss/gain
- ❑ Anemia
- ❑ Alcoholism
- ❑ HIV/AIDS
- ❑ Loss of sleep/difficulty sleeping
- ❑ Poor memory /concentration
- ❑ Learning disability
- ❑ Irritable /nervous /tension
- ❑ Anxiety/ depression
- ❑ Decreased energy / fatigue
- ❑ Tired /lethargic
- ❑ Cancer: _____
- ❑ Weight trouble
- ❑ Sexual dysfunction/Infertility

Musculoskeletal System
- ❑ Headaches: tension /migraine
- ❑ Neck pain /stiffness
- ❑ Tension across shoulders
- ❑ Pain between shoulders /stiffness
- ❑ Numbness /tingling: hands /arms
- ❑ Wrist/hand pain
- ❑ Scoliosis / spinal curvature
- ❑ Hip pain
- ❑ Iliotibial band syndrome
- ❑ Low back pain / stiffness
- ❑ Numbness/tingling in legs/feet
- ❑ Poor posture
- ❑ Painful tailbone
- ❑ Foot trouble, L R
- ❑ Knee pain
- ❑ Foot pain
- ❑ Shin splints
- ❑ Bladder problems
- ❑ Arthritis/swelling

Females Only
- ❑ Painful menstruation
- ❑ Irregular cycle
- ❑ Excessive /irregular flow
- ❑ Excessive cramping/pain
- ❑ Abnormal discharge
- ❑ Hot flashes
- ❑ Past menopause
- ❑ Miscarriages #_____
- ❑ Breast pain/lumps
- ❑ Infertility
- ❑ Currently pregnant? Y or N
- ❑ Date of last menstrual period: _____

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Terms of Acceptance

When a person seeks chiropractic health care and when a chiropractor accepts a person for such care, it is essential that both are speaking and working for the same goal. Chiropractic does NOT treat diseases or symptoms like medicine. Chiropractic has only one goal:

TO LOCATE, ANALYZE, AND CORRECT SPINAL INTERFERENCE TO THE NERVOUS SYSTEM

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The **SUBLUXATION** (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the INNATE healing power of the body to work at maximum efficiency to restore, maintain, and promote health.

I will have an opportunity to discuss with the doctor and/or staff, the nature and purpose of chiropractic adjustments and other procedures, as well as any questions I have regarding the specific Chiropractic technique performed. I understand that the results expected are not guaranteed, as every person is unique.

I hereby request and consent to the performance of chiropractic procedures including diagnostic x-rays, if necessary, on me by the Doctor and/or anyone working in this clinic authorized by the Doctor.

I understand that to provide me with Chiropractic goods and services, Appleview Chiropractor Clinic will collect some personal information about me (e.g., home telephone number, health history). I agree to Appleview Chiropractor Clinic collecting and using personal information about me as it pertains to my health.

I further understand and am informed that, as in all health care, in the practice of manipulation by medical doctors, physiotherapists and chiropractors there are some very slight and minimal risks to care, including, but not limited to: minor muscle strains and sprains, rib fractures, disc injuries and cerebral vascular accidents (CVA). I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I will have an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover todays exam and not withstanding, may exacerbate and irritate your present or current condition.

I understand that the purpose of today's visit is to determine if I am a candidate for chiropractic care and that I am responsible for any fees agreed upon between myself and the attending doctor. All examination fees will be explained to me before any tests are performed.

TO BE COMPLETED BY PATIENT:

_____ _____

SIGNATURE OF PATIENT *PRINT PATIENT'S NAME*
(OR PARENT/GUARDIAN)

_____ _____

DATE SIGNED WITNESS