Fredericton Family Chiropractic:
A Creating Wellness
Centre

Adult
Welcome

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www.FrederictonFamilyChiropractic.ca

1 Personal Information

Today's Date (mm/dd/yy): _____/_____/_____

Name (first/last): _____

Age: _____Gender: M ☐ F ☐ Date of Birth (mm/dd/yy): _____/_____/_____

Address: _____

City: _____ Province: _____ Postal code: _____

Phone (Home): _____ (Other): _____

May we leave phone messages, if need be? Yes ☐ No ☐

Email: _____

May we communicate with you via email? Yes ☐ No ☐

Name of Spouse/Partner: _____

Is your spouse/partner a patient here? Yes ☐ No ☐

What is your occupation? _____

Do you primarily: Sit ☐ Stand ☐ Perform Repetitive Tasks ☐

Names/Ages of Children: _____

_____

How did you hear about us? _____

_____

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2 Healthcare History

Have you had previous chiropractic care? Yes ☐ No ☐

If yes, where? _____ When? _____

Reason for last visit: _____

Do you feel your previous chiropractic care was effective? Yes ☐ No ☐

Please explain: _____

Do you currently see a registered massage therapist? Yes ☐ No ☐

Do you currently see a naturopathic doctor? Yes ☐ No ☐

If yes to either, please explain: _____

_____

Family Medical Doctor: _____ Phone: _____

Date and reason for last visit: _____

_____

May we contact your family doctor regarding your care in this office, if necessary? Yes ☐ No ☐

Have you had an x-ray, MRI, or CT scan done in the last 6-12 months? Yes ☐ No ☐

If yes, for what reason? _____

3 Current Health Profile

What brings you into our office?

☐ I have a specific complaint, symptom, or health concern.

☐ I want to have my spine & nervous system assessed to see if they are functioning as they should.

☐ Other _____

****

If you do not have a specific health concern, skip to the 'Review of Systems' section (Page 6) and ignore the 'Symptom Profile'.

4

Symptom Profile

What is your primary complaint(s)? _____

When did this problem begin? _____

Have you had this type of problem before? Yes ☐ No ☐

Do you believe this problem is from:

☐ one particular event or

☐ an accumulation of numerous injuries/stresses over many years?

Please explain: _____

_____

Please circle the intensity of this problem today: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (severe)

How would you describe the pain/discomfort? _____

_____

Is your problem getting progressively worse or improving? _____

_____

Have you seen any other health care provider for this problem? Yes ☐ No ☐

If yes, please explain: _____

What have you tried that <u>has</u> helped? Ice ☐ Heat ☐ Medication ☐ Massage therapy ☐ Chiropractic ☐

Other ☐ (please specify) _____

What <u>has not</u> helped? Ice ☐ Heat ☐ Medication ☐ Massage therapy ☐ Chiropractic ☐

Other ☐ (please specify) _____

Is your current problem/symptom the result of a motor vehicle accident and/or work related injury?

Yes ☐ No ☐ If yes, please explain: _____

_____

How is this problem affecting your quality of life? (depression, not enjoying normal activities, reducing ability to exercise, too many medications, etc) _____

_____

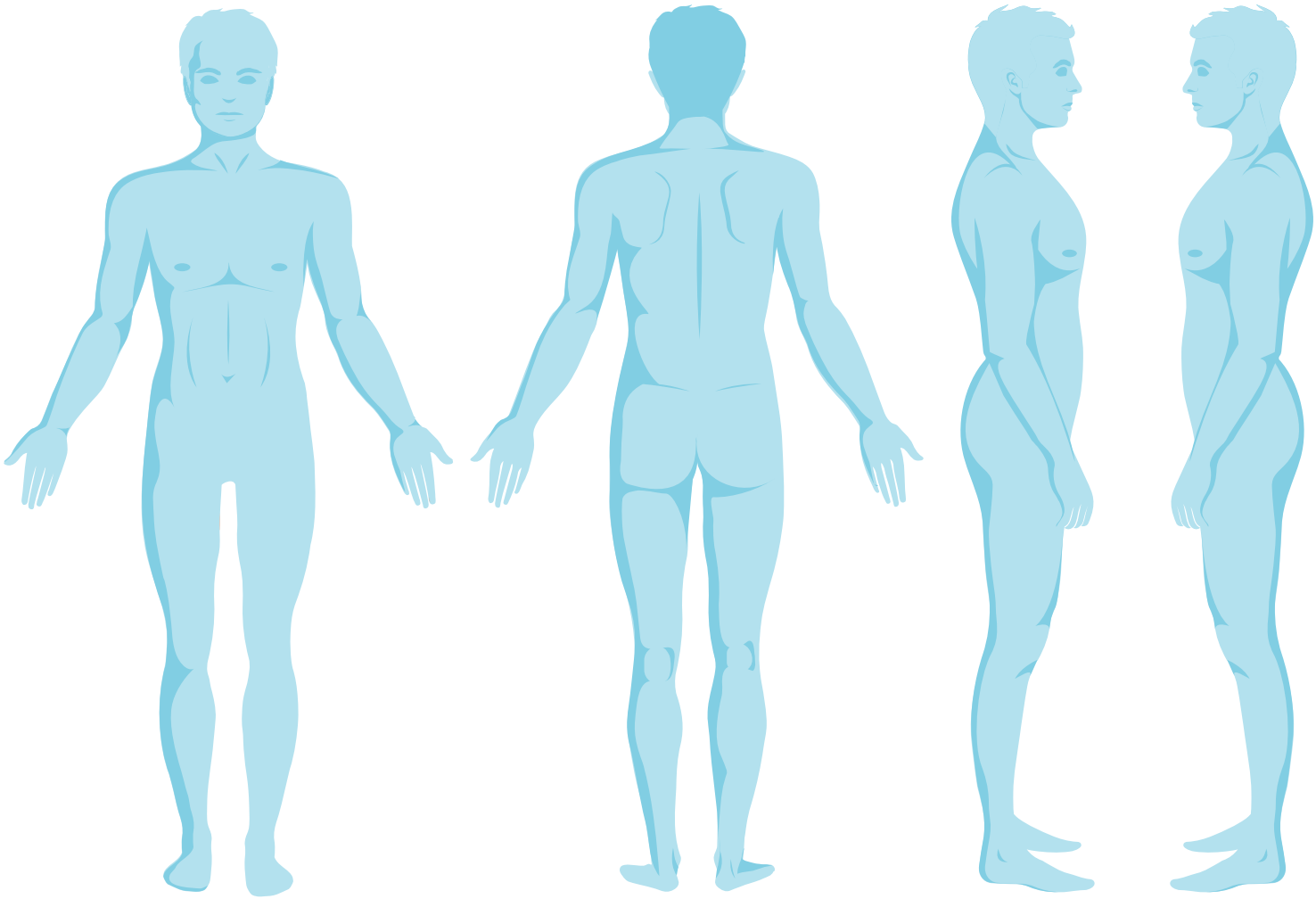
_____

_____

Symptom Profile cont'

Please fill in the diagram with the appropriate symbols from the legend, if applicable:

LEGEND:				
	A = ache	N = numbness	P = pins & needles	T = stiffness
	B = burning	R = radiating	S = stabbing	O = other



Notes: _____

_____

_____

_____

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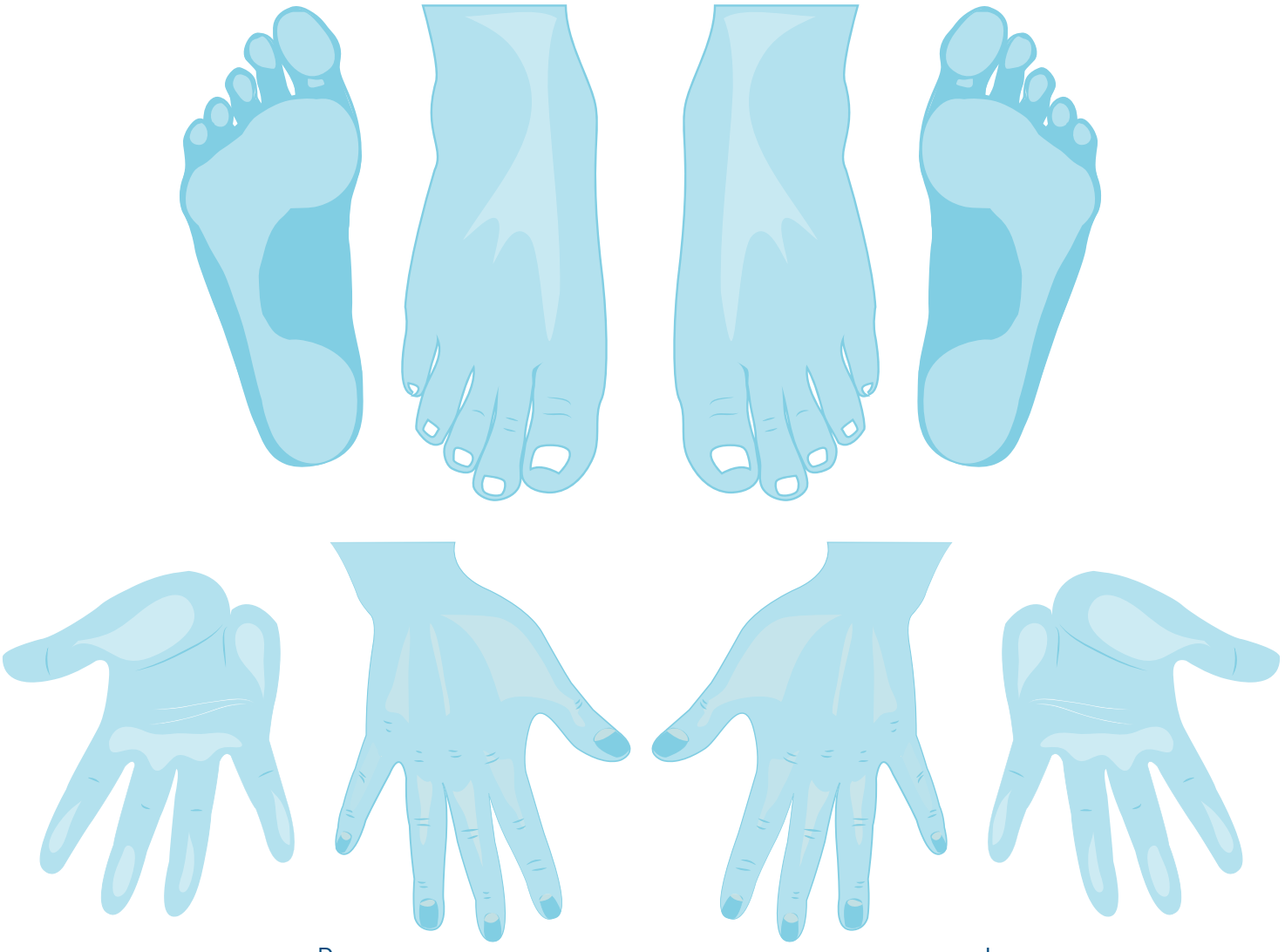
Symptom Profile cont'

Please fill in the diagram with the appropriate symbols from the legend, if applicable:

LEGEND:	A = ache	N = numbness	P = pins & needles	T = stiffness
	B = burning	R = radiating	S = stabbing	O = other



R L

Notes: _____

_____

_____

_____

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Review of Systems - Function of Spinal Nerves

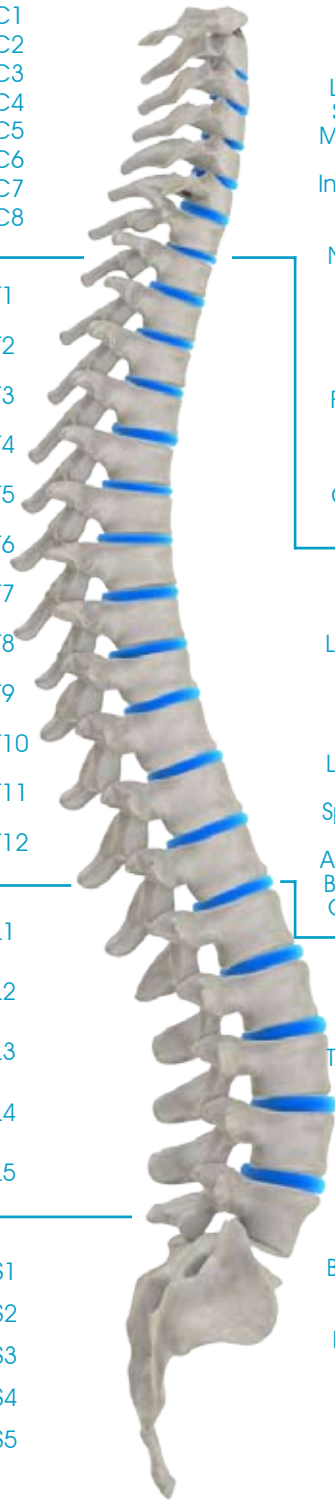
SPINAL NERVE

ORGANS & GLANDS

The organs and glands listed below are linked to the corresponding sections of the spine and it's spinal nerves.

ASSOCIATED SYMPTOMS

Please indicate below any symptoms you are currently experiencing as well as any you have in the past.



C1 C2 C3 C4 C5 C6 C7 C8 | T1 T2 T3 T4 T5 T6

Parotid Gland
Scalp | Base of Skull | Eyes
Lacrimal Gland
Sinuses | Inner, Middle, Outer Ear
Nose | Mouth
Intracranial Blood Vessels
Sympathetic Nervous System
Neck Muscles
Diaphragm
Shoulders
Elbows | Arms
Wrists | Hands
Fingers | Tonsils
Vocal Cords
Esophagus
Heart | Lungs
Chest | Thyroid

CURRENT	PAST	CURRENT	PAST
☐	Sinus & Ear Pain/Infection	☐	Anxiety & Stress
☐	Runny Nose & Allergies	☐	Seizures
☐	Frequent Head Colds	☐	ADD/ADHD
☐	Sore Throat & Tonsillitis	☐	Thyroid Dysfunction
☐	Strep Throat	☐	Metabolic Dysfunction
☐	Chronic Cough & Croup	☐	Insomnia
☐	Difficulty Breathing	☐	High/Low Blood Pressure
☐	Poor Immunity	☐	Enlarged Lymph Glands
☐	Dizziness & Vertigo	☐	Migraines & Headache
☐	Tinnitus & Ear Fullness	☐	TMJ Pain
☐	Vision Problems	☐	Stiff Neck
☐	Watery/Dry Eyes	☐	Arm Pain
☐	Chronic Fatigue	☐	Hand/Finger Numbness
☐	Poor Concentration	☐	Loss of Grip Strength
☐	Depression		

T7 T8 T9 T10 T11 T12

Arms | Wrists
Esophagus
Chest | Heart
Lungs | Trachea
Larynx
Diaphragm
Stomach
Gallbladder
Liver | Pancreas
Small Intestine
Spleen | Kidneys
Appendix
Adrenals | Colon
Buttocks | Uterus
Ovaries | Testes

☐	Asthma	☐	Kidney Stones
☐	Bronchitis & Pneumonia	☐	Gall Bladder Attacks
☐	Congestion	☐	Skin Conditions & Rashes
☐	Reflux & GERD	☐	Menstrual Cramps/PMS
☐	Indigestion & Heartburn	☐	Infertility
☐	Stomach Pains	☐	Menstrual Dysfunction
☐	Ulcers	☐	Rashes & Eczema
☐	Gas & Bloating	☐	Hyperactivity
☐	Jaundice	☐	Shoulder Pain
☐	Liver Conditions	☐	Midback Pain
☐	Blood Sugar Dysregulation	☐	Rib Pain

L1 L2 L3 L4 L5

Large Intestine
Colon
Thighs | Buttocks
Groin | Knees
Legs | Feet
Reproductive Organs

☐	Irritable Bowel, Colitis, Chrohn's	☐	Prostate Dysfunction
☐	Gas Pain & Constipation	☐	Ovarian Cysts & Endometriosis
☐	Diarrhea	☐	Fertility Problems/ Loss of Menstruation
☐	Hemorrhoids	☐	Low Back Pain
☐	Bladder Incontinence/Bed-wetting	☐	Hip Pain
☐	Painful/Excessive Urination	☐	Thigh Pain
☐	Impotence	☐	Numbness & Tingles in Legs

S1 S2 S3 S4 S5

Buttocks | Groin
Legs | Ankles
Feet | Toes
Prostate Gland
Bladder
Reproductive Organs

☐	Varicose Veins	☐	Sciatica
☐	Leg Cramping	☐	Pelvic Pain
☐	Restless Legs	☐	Knee Pain
☐	Poor Circulation & Cold Feet	☐	Ankle Pain & Sprains
		☐	Foot Pain & Weak Arches

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Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage to our nervous system. The result is a condition called a ***Vertebral Subluxation*** *which may impede your body's ability to heal and function properly. The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation(s) in your spine.*

CHILDHOOD (0-18 years):

Please describe any childhood illnesses, surgeries, serious falls, car accidents, emotional trauma, prolonged use of medication (antibiotics or inhalers), and birth trauma:

_____

_____

_____

_____

ADULTHOOD (18+ years):

Physical Stress

Please list any previous surgeries (include dates):

_____

_____

Traumas, accidents, falls, injuries, sports (please be specific):

_____

_____

Have you ever been diagnosed with a serious disease or condition?

_____

_____

How often do you exercise?	Rarely ☐	1-3 times/wk ☐	>3 times/wk ☐
How often do you stretch?	Rarely ☐	1-3 times/wk ☐	>3 times/wk ☐
How old is your current pillow?	<6 mths ☐	6mths - 2yrs ☐	>2yrs ☐
How old is your current mattress?	<1 yr ☐	1 - 8yrs ☐	>8yrs ☐

Lifestyle Information cont'

On an average week, how many hours do you spend:

sitting at a desk?	0 ☐	1-5 ☐	6-10 ☐	11-20 ☐	21-40 ☐	41+ ☐
on a mobile device?	0 ☐	1-5 ☐	6-10 ☐	11-20 ☐	21-40 ☐	41+ ☐
watching TV?	0 ☐	1-5 ☐	6-10 ☐	11-20 ☐	21-40 ☐	41+ ☐
playing video games?	0 ☐	1-5 ☐	6-10 ☐	11-20 ☐	21-40 ☐	41+ ☐
commuting?	0 ☐	1-5 ☐	6-10 ☐	11-20 ☐	21-40 ☐	41+ ☐

Chemical Stress

Are you taking any medications (over the counter/prescribed)? Yes ☐ No ☐

If yes, please list: _____

_____

Is there a plan in place with your doctor to wean you off of any long-term medication? Yes ☐ No ☐

Have you had any recent vaccinations? Yes ☐ No ☐

If yes, please list: _____

How many servings of fruit do you consume each day? 3 or less ☐ 3-5 ☐ 5 or more ☐

How many servings of vegetables do you consume each day? 3 or less ☐ 3-5 ☐ 5 or more ☐

How often do you consume sugary and/or processed foods?

>3 times / day ☐ 1-3 times / day ☐ 1-3 times / wk ☐

How much caffeine do you consume daily? 0 ☐ 1-3 cups ☐ >3 cups ☐

How much water do you drink daily? <1L ☐ 1-2L ☐ 2+ Litres ☐

Do you take a vitamin D supplement? Yes ☐ No ☐ Sometimes ☐ If yes, how much? _____

Do you take an omega3 (fish oil) supplement? Yes ☐ No ☐ Sometimes ☐

Do you take a probiotic supplement? Yes ☐ No ☐ Sometimes ☐

Lifestyle Information cont'

Emotional Stress:

Current emotional/mental state: Excellent ☐ Good ☐ Poor ☐

Do you feel you have healthy coping strategies for life stress? Yes ☐ No ☐

If yes, what are they? _____

_____

_____

Please list any emotional/mental stressors presently in your life and any previous major stressors:

Present	Past

Do you experience depression and/or anxiety? Often ☐ Sometimes ☐ Rarely ☐

Do you feel that you worry about the small things? Often ☐ Sometimes ☐ Rarely ☐

Do you have difficulty thinking or concentrating? Often ☐ Sometimes ☐ Rarely ☐

Do you feel joy or happiness on a daily basis? Often ☐ Sometimes ☐ Rarely ☐

Do you wake up feeling rested? Often ☐ Sometimes ☐ Rarely ☐

Do you feel fatigued or have low energy? Often ☐ Sometimes ☐ Rarely ☐

How often do you get colds/flu/sore throats/etc? Often ☐ Sometimes ☐ Rarely ☐

How many hours of sleep do you get at night? <6 hrs ☐ 7-9 hrs ☐ 9+ hrs ☐

Which of the following do you do to help relieve stress and improve your health? (check all that apply)

chiropractic care ☐ bodywork/massage ☐ meditation ☐ yoga ☐ cardiovascular exercise ☐

weight training ☐ balanced nutrition ☐ pilates ☐ other ☐ _____

Are you healthier than you were 2 years ago? Yes ☐ No ☐

Do you believe you will be healthier 2 years from now? Yes ☐ No ☐

Please explain: _____

_____

_____

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7

Final Thoughts

What are the top 3 outcomes you hope to achieve by consulting our office?

1) _____

2) _____

3) _____

Do you have other concerns about your health that we have not addressed but you would like us to know about? Yes ☐ No ☐

If yes, please explain:

_____

_____

_____