Personal Health Profile

The purpose of our office is to focus on your ability to be healthy. Our goal is to addresss the issues you have and offer you an opprotuntiy to improve your health and wellness. Please complete this confidentical health questionnaire fully and accurately. The more we know about your overall health, the better we will be able to help you.

Personal Information			
Name:			Date:
Physical & Mailing Address:			Cell Ph:
City:	Province:	Postal Code:	Home Ph:
Email:			Work Ph:
(email for information purposes only, unsubscibe option is availble.) Our email info@elkvalleychiropractic.com			
DOB: MM DD YY	Age:	Gender: M F	Spouse's Name:
Marrital Status: Single Married C/L Partner Widowed			Children? Names & Age:
Occupation:			
Employer:			Who May we Thank for Referring you?
Health Card #			Extended Health Insurance? Y N
Medical Doctor: Other Wellness practitioners: (massage/ acupunture/ dentist etc.)			Reason for consulting our office?
Have you been under regular chiropractic care? Yes No			With Whom?
When was your last chiropractic adjustment?			New to Chiropractic / Any Concerns

Health History				
Child(Age 0-17) (please check each block)	Yes	No	Unsure	Comments
Was your birth difficult? (forceps/suction)				
Did you have any childhood illnesses?				
Any serious falls as a child?				
Childhood sport related injuries?				
Any surgeries as a child?				
Prolonged use of medication?(inhaler/ antibiotics)				
Were you vaccinated?				
Were you under regular chiropractic care?				
Adult (Age 18 - present)				
Any head injuries?				
Do/did you smoke? Do/did you smoke?				
Do/did you drink alcohol?				
Have you been in any accidents?				
Have you had any surgery?				
Have you had any foot problems?				
Do you wear orthotics?				

Personal Health Profile

Elk Valley Family Chiropractic

If you have no symptoms or complaints, and are here for wellness service, please circle **"Wellness Service"** and skip to **"Family Health Profile"**

CHECK ANY OF THE CONDITIONS YOU CURRENTLY EXPERIENCE (even if doesn't relate to your problem):

O Headache/ Mirgraine	O Irritability/ Mood swings	O Constipation	O Fever
O Dizziness	O Anxiety/ Nervousness	O Asthma	O Hot Flashes
O Ringing in ears	O Back Pain	O High Blood Pressure	O Cold sweats
O Vertigo	O Neck Pain	O Stroke/ Heart attack	O Cold Hand & Feet
O Earache	O Tension/ Pain in shoulders	O Heart Burn	O Fainting
O Sinus Trouble	O Arm/ hand pain or tingling	O Loss of taste/ smell	O Stomach Pain/ Ulcers
O Allergies	O Foot Pain or tingling	O Loose Stools	O Irrregular Menstrual
O Depression	O Numbness in any body parts	O Loss of balance	O Painful Menstrual
O Fatigue	O Problems urinating	O Loss of sleep	O Poor Concentration

Place a dot ● on each line below to indicate your level on the scale

Stress	High	———	Low
Sleep	Poor	———	Best Possible
Exercise	Poor	———	Best Possible
Diet	Poor	———	Best Possible
Health	Poor	———	Best Possible

Please list the main area's of complaint:

1

2

3

Please rate your level of commitment to solving this/ intake 2

1 2 3 4 5 6 7 8 9 10

Does it interfere with:

O Leisure O Sitting O Walking O Sleep O Work

List of Medications/ Drugs, you are taking:	**Any Vitamins/ Herbals:**	**On average how much:**
		Water do you drink per day? Coffee or Tea do you drink per day? Pop do you drink per day?

Family Health Profile

Our office is not only interested in your health and well being, but also the health and well being of your family. Please mention below any health conditions or concerns you may have about your: (Children/ Spouse/ Parents/ Siblings/ Friends)

The statements on this form are accurate to the best of my recollection and I agree to allow this office to exmaine me for further evaluaiton:

Signature: _____ Date: _____

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