Holroyd Family Chiropractic Inc.
West Kelowna – 250.707.0711

PERSONAL HEALTH PROFILE

Name:			Date:
Home Address:			Town:
Postal Code:	Email Address:		
Home Phone:	Work Phone:		Best phone # to reach you:
Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Other	Spouse's Name:		Height: Weight:
DOB: MM DD YY	Age:	Gender: ❒ M ❒ F	Current Job:
Where do you work?			Children? Names & Age:
Have you ever received chiropractic care before? ❒ No ❒ Yes Approx. Date of Last Visit? Happy with Results? ❒ No ❒ Yes			
Who May we Thank for Referring you?	BC Medical Card # ❒ MSP		

YOUR PRIMARY CONCERN TODAY

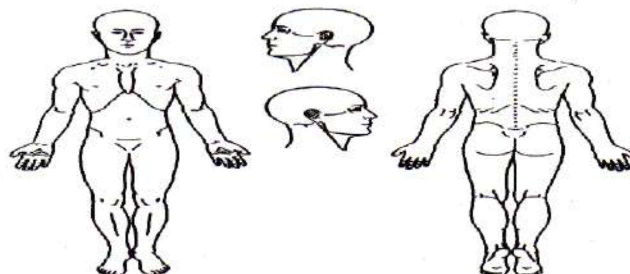
Is this visit for a wellness checkup? ❒ Yes ❒ No If this is for a specific concern, proceed below:

	Primary Concern	*Secondary* Concern
Specific Concern (s) and location		
How long have you had this?		
How would you describe the pain?	❒ sharp ❒ dull/achy ❒ burn ❒ pins/needles	❒ sharp ❒ dull/achy ❒ burn ❒ pins/needles
How often does this happen?	❒ daily ❒ weekly ❒ on/off	❒ daily ❒ weekly ❒ on/off
On a scale of 1 to 10 (*10 being worst*), rate it now		
What makes it worse? (sitting, standing, etc.)		
What have you tried to address this concern?		
At its worst, this problem interferes with:		

USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATION OF YOUR SENSATIONS:

A=ACHE **B=BURNING** **N=NUMBNESS**

P=PINS & NEEDLES **S=STABBING** **O=OTHER**



PLEASE CHECK ANY OF THE FOLLOWING SIGNS OF ORGAN MALFUNCTION OR DISEASE YOU HAVE EXPERIENCED:

O Blurred /failing vision
O Deafness /ringing in ears
O Earaches
O Sore throat /tonsillitis
O Thyroid problems
O Sinus problems

Cardiovascular system

O Chest Pain
O Shortness of Breath
O Heart Medication
O High Blood Pressure Medication
O High Cholesterol Medication
O Swelling of Legs

Respiratory system

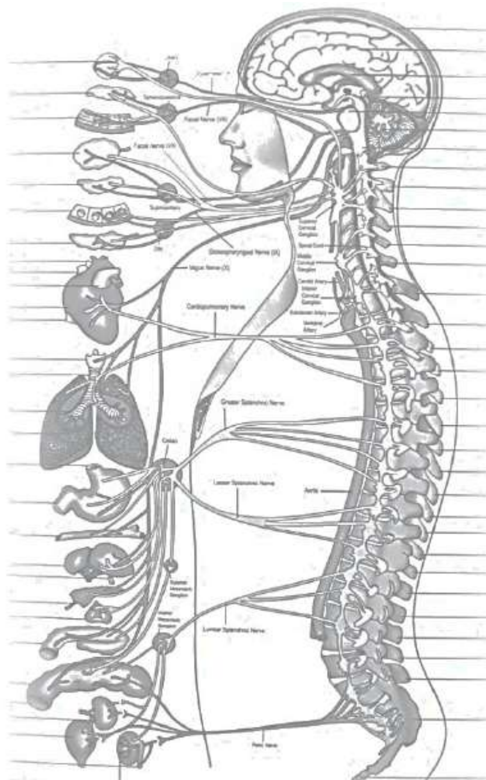
O Frequent bronchitis
O History of pneumonia
O Chronic cough
O Spitting up phlegm /blood
O Difficulty breathing
O Tuberculosis
O Pneumonia

Digestive system

O Heartburn / indigestion
O Stomach Cramps
O Constipation /diarrhea
O Food Allergy
O Irritable Bowel Syndrome
O Crohn's Disease
O Ulcers
O Belching /gas
O Nausea or vomiting
O Liver /gall bladder trouble
O Colon trouble
O Black /bloody stool

Musculoskeletal system

O Painful Joints O Bursitis
O Painful Muscles O Arthritis
O Tendinitis



Females Only

O Painful menstruation O Excessive /irregular flow
O Cramps or backaches O Abnormal discharge
O Passed menopause O Miscarriages # ____
O Currently pregnant? O Yes O No
Date of last menstrual period: _________________

General Symptoms

O Fever / chills / sweats
O Frequent colds
O Fainting / dizziness
O Seizures / convulsions
O Headaches /migraine
O Neck pain /stiffness
O Tension across shoulders - Left or Right
O Mid-back pain /stiffness
O Numbness /tingling: hands /arms

General Symptoms

O Skin problems
O Tremors
O Loss of balance
O Unexplained weight loss/gain
O Anemia
O Alcoholism
O HIV/AIDS
O Loss of sleep
O Poor memory /concentration
O Learning disability
O Irritable /nervous /tension
O Depression /emotional problems
O Decreased energy / fatigue
O Tired /lethargic
O Autoimmune Disease
O Antibiotic Use
O Cancer:
O Allergies / Asthma
O Scoliosis / spinal curvature
O Low back pain / stiffness
O Faulty posture
O Painful tailbone
O Foot trouble - Left or Right

YOUR CHILDHOOD HISTORY

Birth:	❒ Born by Forceps	❒ Born by Cesarean	❒ Born Breech	❒ Natural (no drugs)
Habits/Stressors:	❒ stomach sleeper	❒ on antibiotics	❒ used puffers	❒ had a jolly jumper
Childhood surgeries:				
Childhood injuries/falls:				
Contact sports (list):				

AFTER CHILDHOOD TO PRESENT

Lifestyle:	❒ Smoke?______/ wk ❒ Alcohol?___/ week ❒ Rec drugs? _______ ❒ Exercise?____/ week ❒ Eat junk food_________/ wk ❒ Carry Excessive Weight / Overweight? ______			
Habits/Stressors:	❒ Home stress	❒ Work Stress	❒ Sit at work	❒ Stomach sleeper
Surgeries (list):				
Car accidents or injuries:				
Falls / Broken Bones:				
Other Health Problems/ Diseases:				

Holroyd Family Chiropractic 2418 Drought Rd West Kelowna BC V4T 1P6 250 707 0711

Medications (list):	O Pain killers ____________________ O Anti-inflammatories____________________ O Muscle Relaxants____________________ O Blood Pressure Meds____________________ O Cholesterol (statins)____________________ O Anti-depressants____________________ O Tranquilizers, Anti-anxiety ____________________ O Blood Thinners ____________________ O Birth Control Pills____________________ O Other____________________	Vitamins (list): Omega 3 Fatty Acids (Fish Oil) Probiotic Vitamin D Multivitamin Other____________________ ____________________ ____________________ ____________________

FAMILY HEALTH HISTORY

What Significant health concerns have your family members experienced?
Parents:
Siblings:
Spouse/Partner:
Children:

GOAL FOR CARE

Health is more than just physical function. Health certainly includes physical health, but also incorporates emotional health, mental health, social health, and spiritual health. What things/areas in your life would you like to see improve over the next 12 months (please be specific):

____

____

What is the best part about your health and overall wellbeing?

____

____

I hereby authorize the doctors to examine my condition, including X-rays if necessary, and determine a care plan. I understand and agree that all services rendered are charged directly to me and that I am personally responsible for this payment. I understand that fees for professional services are due when rendered. I understand that if I suspend or terminate my care, any professional services rendered will become immediately due and payable.

Our Fee Structure:
Initial Visit: Consultation and Exam Fee = $85
X-ray Fee = $100
Total = $185
Regular Office Visit = $55

❒ **(Check if applicable) I have health coverage through ____________________ I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself.**

- ❑ **I would like to opt out of email appointment reminders.**
- ❑ **I would like to opt out of email newsletters.**

____ ____________________

(Signature) I have read and understand the material above **Date**