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

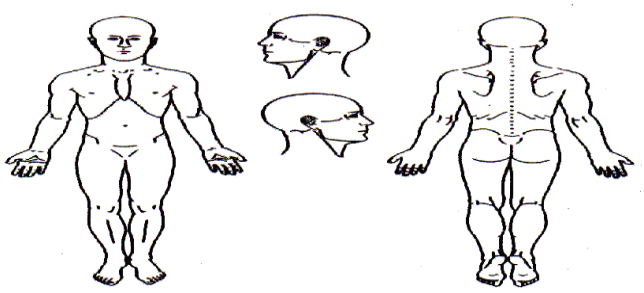
Is this visit for a wellness checkup? ☐ *Yes* ☐ *No* *If this is for a specific concern, proceed below:*

	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:

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

Cardiovascular system

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

Respiratory system

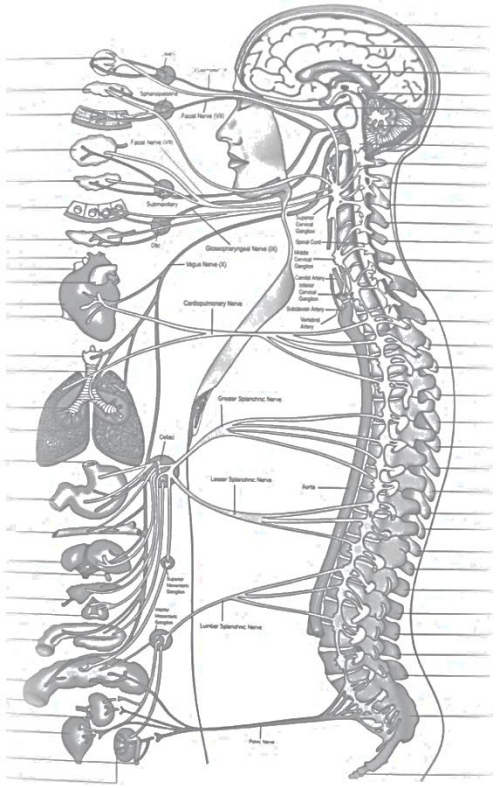
- ☐ Frequent bronchitis
- ☐ History of pneumonia
- ☐ Chronic cough
- ☐ Spitting up phlegm /blood
- ☐ Difficulty breathing
- ☐ Tuberculosis
- ☐ Pneumonia

Digestive system

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

Musculoskeletal system

- ☐ Painful Joints ☐ Bursitis
- ☐ Painful Muscles ☐ Arthritis
- ☐ Tendinitis



Females Only

- ☐ Painful menstruation ☐ Excessive /irregular flow
- ☐ Cramps or backaches ☐ Abnormal discharge
- ☐ Passed menopause ☐ Miscarriages # ____
- ☐ Currently pregnant? ☐ Yes ☐ No

Date of last menstrual period: _____

General Symptoms

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

General Symptoms

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

Medications (list):	☐Pain killers _____ ☐Anti-inflammatories_____ ☐Muscle Relaxants_____ ☐Blood Pressure Meds_____ ☐Cholesterol (statins)_____ ☐Anti-depressants_____ ☐Tranquilizers, Anti-anxiety _____ ☐Blood Thinners _____ ☐Birth Control Pills_____ ☐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 = $95
X-ray Fee = $100
Total = $195
Regular Office Visit = $60

☐ **(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**