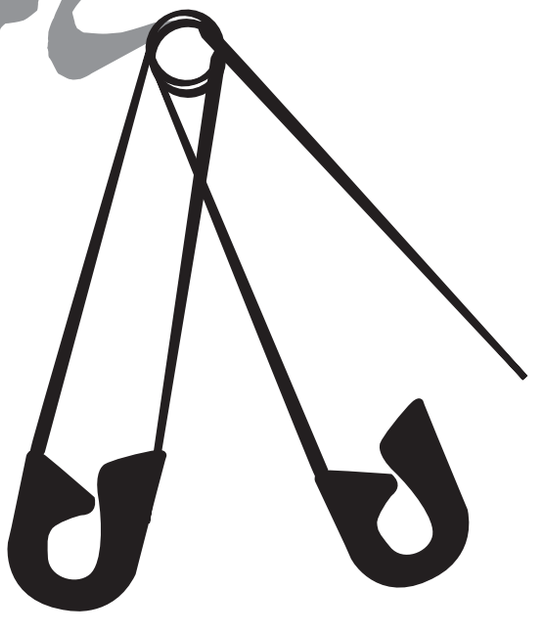
THE SAFETY PIN Life SYSTEM



HEALTH SIGNALS - DISCOVERY
DISEASE CAUSATION ANALYSIS

THE SAFETY PIN *Life* SYSTEM

Our office takes a unique approach to achieving and maintaining optimal health and healing.
A unique approach that gets results! We know you likely just want us to make your body feel better. The truth is for you to feel better your body needs to heal the problem causing the symptoms.

The Safety Pin Cycle is a metaphor from almost a century ago that refers to the constant flow of nerve signals from the brain to every cell of your body, and then from that cell back to your brain; like the continuous loop of a closed safety pin. Any interference to that safety pin interrupts that loop, disrupting the nerve connection that controls the function and healing in your body; like opening a safety pin.

Today in Canada, and the rest of the western world, the priority in health care is to help people after they are already sick or having symptoms. When we only focus on relieving symptoms or health issues once they are there, we lose focus on true health. True health is about having every part of your body strong and healthy which makes it function at its best, feel great, and is less prone to injury, illness and disease. We want to help someone get better and feel better but the best approach is keeping your body strong and healthy long term.

Wouldn't it be great if we could work at staying strong and healthy, instead of treating issues as they flare up, year after year. Wouldn't it be great to do things at the age of 50 that you thought were impossible to do at the age of 40, or even 30?

That is exactly what **THE SAFETY PIN *Life* SYSTEM** is designed to do. **We are here to help you live stronger and healthier, doing the things YOU want to do!**

That is living life FULLY ALIVE!

How does **THE SAFETY PIN *Life* SYSTEM** work?

1. HEALTH SIGNALS - DISCOVERY

Unique questions will lead to new answers.

We will begin by looking at the current state of your health and function. In essence, how are you doing right now? We will also ask you some detailed questions about your history and your family health history.

In our experience, your current health problem likely started years ago with many contributing causes. We know, it rarely feels like that, it feels like it started with one bad move! That can happen from an acute trauma like a car accident or severe sports injury. Even with acute traumas the extent of the injuries is often dependent on the strength and health of the stressed area before the accident. Your answers to the following questions offer up clues to what areas of your body are currently under stress and/or not at optimal strength and health. We will find out why!

2. DISEASE CAUSATION ANALYSIS

We will explore which lifestyle factors are affecting your overall health and your ability to live **FULLY ALIVE**. Most of the risk factors for the two most feared diseases; heart disease and cancer, are lifestyle related. The same is true for the majority of chronic illnesses affecting patients today. Often lifestyle is the best predictor of what parts of your body are under the most stress and most prone to injury, illness or disease. We will guide you in improving this!

Let's get started in understanding your health concerns and finding a solution.

HEALTH SIGNALS - DISCOVERY

PERSONAL INFORMATION

Name: _____

Address: _____

City: _____ Postal Code: _____

Email: _____

Home #: _____ Age: _____ Birth date: (M) _____ (D) _____ (Y) _____

Workplace: _____ Office #: _____ Occupation: _____

Referred by: _____

○ Single ○ Widowed ○ Married (SPOUSE'S NAME): _____ ○ Common Law/Partner (NAME): _____

Children's names & ages: _____ _____

_____ _____

PREVIOUS TRAUMAS

MOTORIZED VEHICLE ACCIDENTS

Year: _____ Injuries: _____
Year: _____ Injuries: _____
Year: _____ Injuries: _____

☐ High Speed Collisions >40km/h? ☐ Vehicles unrepairable?
☐ Whiplash injury? ☐ Un-belted accident?

SPORTS & RECREATION:

Sports injuries: _____
_____

Participation in High Impact Activities:

☐ Hockey ☐ Wrestling ☐ Basketball
☐ Running ☐ Mountain bike ☐ Climbing
☐ Football ☐ Gymnastics ☐ _____

FALLS

Falls from heights _____
Falls down stairs _____
Other falls _____
Broken bones _____
Childhood falls _____
_____
_____

Falls from:

☐ Trees ☐ Roof ☐ Play structure ☐ Bicycle

OCCUPATIONAL STRESSES

Occupation _____
Tasks _____
Work injuries _____
_____
Home injuries _____
My job requires:

☐ Heavy Lifting ☐ Awkward positions
☐ Repetitive stresses ☐ Sitting long periods

POSTURES & HABITS

☐ Sitting >6 hours/day ☐ Stomach sleeper
☐ Head forward posture

BIRTH TRAUMA was your delivery

☐ Difficult ☐ Forceps ☐ C-section
☐ Epidural ☐ Suction ☐ Resuscitation

HEALTH SIGNALS - DISCOVERY

WHAT ARE YOUR PRESENT HEALTH CONCERNS?

_____

_____

How long have you had this condition?

_____

Have you had a similar condition in the past?

_____

What activities aggravate your condition?

_____

What relieves your condition?

_____

Are you getting pain or numbness in your arms or legs?

_____

Is your condition getting progressively worse?

☐ Yes ☐ No ☐ It's constant ☐ It comes and goes

Pains are: ☐ Sharp ☐ Dull ☐ Burning

☐ Tightness ☐ Throbbing

Pain severity (0 no pain; 10 most severe)

0 1 2 3 4 5 6 7 8 9 10

How is this condition interfering with your life?

☐ Work ☐ Daily Routine ☐ _____

Who else have you seen for this condition?

_____

What were the outcomes of their care?

_____

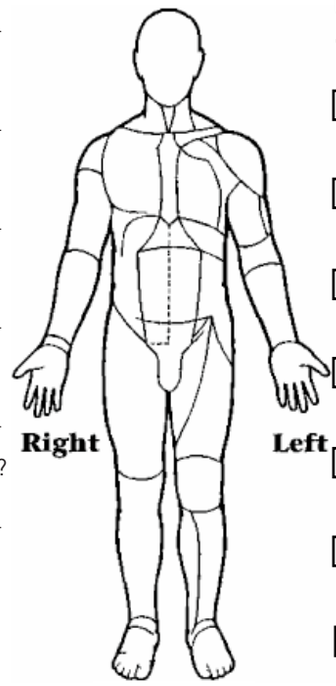
FAMILY HEALTH PROBLEMS?

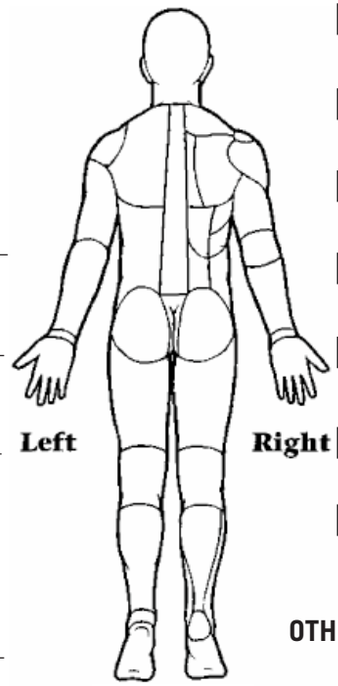
_____

_____

_____

_____





USE THE HIGHLIGHTER TOOL ON THE ACROBAT TOOLBAR TO MARK ON THE DIAGRAM ANY PAST OR PRESENT PAIN OR PROBLEMS. THEN CHECK THE APPROPRIATE BOX BELOW:

☐ Headaches ☐ Facial Pain

☐ Vision problems ☐ Hearing problems

☐ Shoulder: ☐ Pain ☐ Numbness ☐ Tingling

☐ Arm: ☐ Pain ☐ Numbness ☐ Tingling

☐ Hand: ☐ Pain ☐ Numbness ☐ Tingling

☐ Hip: ☐ Pain ☐ Numbness ☐ Tingling

☐ Knee: ☐ Pain ☐ Numbness ☐ Tingling

☐ Foot: ☐ Pain ☐ Numbness ☐ Tingling

☐ Neck Pain

☐ Upper Back Pain

☐ Middle Back Pain

☐ Low Back Pain

☐ Sacroiliac Pain

☐ Leg: ☐ Pain ☐ Numbness ☐ Tingling

☐ Upper ☐ Lower ☐ Front ☐ Back

OTHER HEALTH PROBLEMS?

_____

_____

_____

_____

HEALTH SIGNALS - DISCOVERY

PLEASE CHECK ANY OF THE FOLLOWING SIGNS OF ORGAN MALFUNCTION OR DIS-EASE YOU HAVE EXPERIENCED:

- ☐ Blurred /failing vision
- ☐ Deafness /ringing in ears
- ☐ Earaches
- ☐ Sore throat /tonsilitis
- ☐ 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

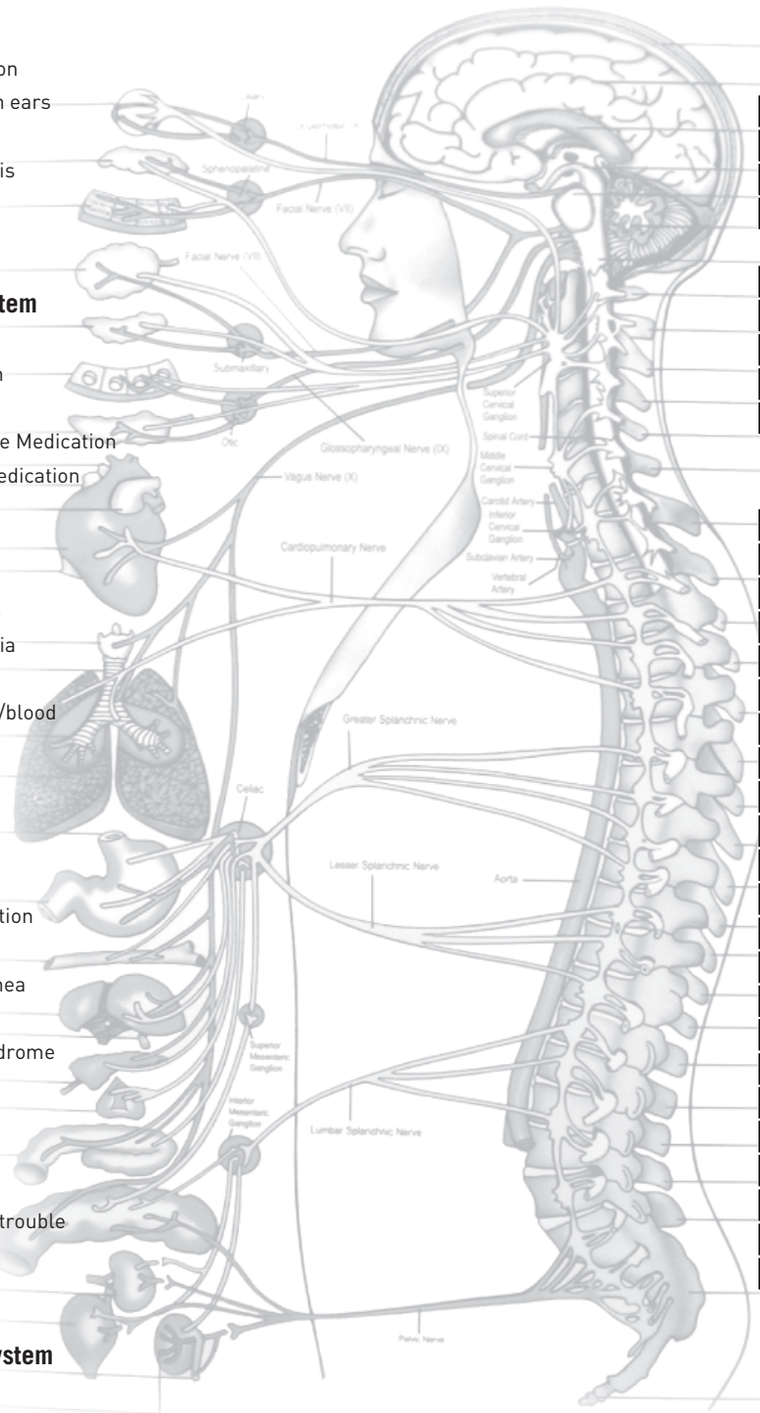
- ☐ Frequent bronchitis
- ☐ History of pneumonia
- ☐ Chronic cough
- ☐ Spitting up phlegm /blood
- ☐ Difficulty breathing
- ☐ Tuberculosis
- ☐ Pneumonia

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



General Symptoms

- ☐ Fever / chills / sweats
- ☐ Frequent colds
- ☐ Fainting / dizziness
- ☐ Seizures / convulsions

- ☐ Headaches /migraine
- ☐ Neck pain /stiffness
- ☐ Tension across shoulders, L ☐ R ☐
- ☐ Mid-back pain /stiffness
- ☐ Numbness /tinglining: 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, L ☐ R ☐

Females Only

- ☐ Painful menstruation
- ☐ Cramps or backaches
- ☐ Passed menopause
- ☐ Currently pregnant? Y ☐ N ☐

- ☐ Excessive /irregular flow
- ☐ Abnormal discharge
- ☐ Miscarriages #_____

Date of last menstrual period: _____

HEALTH SIGNALS - DISCOVERY

PERSONAL INFORMATION

How has your condition affected your quality of life? _____

_____

_____

How has your condition affected you emotionally?_____

_____

_____

How has your condition affected your family life and/or relationships? _____

_____

_____

If left uncorrected, how do you see your condition affecting your life over the next 1-5 years? _____

_____

_____

If you are a candidate for **our care** and if we were having this conversation 12 months from today, what has to happen over that time to make you feel happy with your progress? _____

_____

_____

What is your greatest motivation (other than pain) for seeking out a solution for your condition?
(Mobility, quality of life, family, participation in sports, etc.) _____

_____

_____

_____

Do you believe that this condition can improve? _____

_____

In your mind, what are some ways that you can help yourself get better?_____

_____

_____

_____

DISEASE CAUSATION ANALYSIS

EXERCISE

Do you participate in aerobic exercise at least 30 minutes per day?

- ❍ 0 days /week
- ❍ 1-2 days /week
- ❍ 3-4 days /week
- ❍ 5-7 days /week

Do you lift weights or do resistance training?

- ☐ Personal Trainer: _____
- ☐ Gym membership / name of gym: _____
- ☐ Home program - self guided: _____
- ☐ DVD / name of program: _____
- ☐ Other _____

What activities are you involved in that require balance?

_____ ☐ None

How often do you stretch per week?

- ❍ 0 days /week
- ❍ 1-2 days /week
- ❍ 3-4 days /week
- ❍ 5-7 days /week

How many days a week do you sit for over 5 hours?

- ❍ 0 days /week
- ❍ 1-2 days /week
- ❍ 3-4 days /week
- ❍ 5-7 days /week

EMOTIONAL STRESS

Are you currently experiencing, or have you ever experienced significant stress in the following areas?

- ☐ Marriage _____
- ☐ Kids _____
- ☐ Finances _____
- ☐ Work _____
- ☐ Elderly Parents - Caregiver _____
- ☐ Recent Major Life Events (births, deaths) _____

_____

FAMILY HEALTH HISTORY

What significant health concerns have your family members experienced?

Parents / Siblings:_____

_____

Spouse / Partner:_____

_____

Children: _____

_____

_____

CHEMICAL STRESSES: NUTRITION

Do you feel that you make healthy food choices?

❍ Yes ❍ No ❍ Don't Know

How often, and/or how much? _____

Do you have a high intake of fruits and vegetables?

❍ Yes ❍ No ❍ Don't Know

Do you have a high intake of lean meat for protein?

❍ Yes ❍ No ❍ Don't Know

Are you at your ideal body weight?

❍ Yes ❍ No ❍ Don't Know

CHEMICAL STRESSES: TOXIC LOAD

Do you presently, or have in the past:

- ☐ Smoke?
- ☐ Carry excessive weight?
- ☐ Consume Alcohol?
- ☐ Take recreational drugs?

How often, and/or how much? _____

_____

MEDICATIONS

For what condition(s)? _____

_____

_____

_____

_____

_____

SURGERIES

For what condition(s)? List (year performed) _____

_____

_____

_____

_____

_____

_____

Any other details that may assist the Doctor in understanding your lifestyle and health status: _____

_____

_____

_____

_____

_____