151-2515-90 Avenue SW, Calgary, AB T2V 0L8 Tel: (403) 251-0002 info@oakbaychiro.ca

Health and Wellness Profile

Name____ Date__________________

Date of Birth d______m______y______ Sex: Male / Female Alberta Health Care__________________________

Address____

Mailing Address City Province Postal Code

Phone Home ( ) _____-___________ Business ( ) _____-__________ *Cell ( ) _____-__________

Occupation_________________________________

Is this a Workers compensation claim? *Yes / No* Is this an Auto Accident Claim? *Yes / No*

*E-mail Address __________________________________

*Would you like text or email reminders for future appointments? Yes/No

If text indicate your service provider _____________________

Do we have your consent to send you clinic updates for office closures, announcements, newsletters, etc? Yes/ No

Emergency Contact___________________________ Phone Number_______________________________

Who may we thank for referring you to our practice____

We only accept cases that through examinations and testing we are confident we can help, so please fill out the following information thoroughly to give us the most complete picture of your health profile. Please feel free to ask any questions if you need assistance. We look forward to serving you.

Describe the reason for your visit? How did you hurt yourself?

____

____

____

How is it affecting your life?

____

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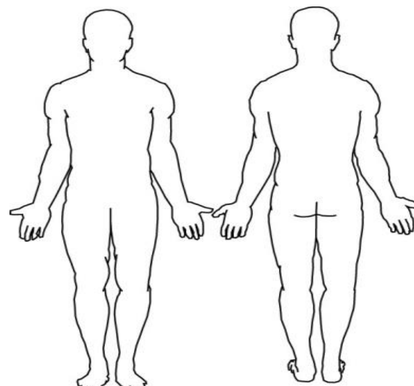
Please indicate the areas of your body in which you are currently experiencing symptoms

Numbness	####
Pin & Needles	^^^^
Burning	++++
Aching	OOOO
Stabbing	| | | |



Where does it hurt?	When did it start?	What makes it worse?	What makes it better?	Quality – Numb, Sharp, Tingling, etc.	Does pain go down arm/leg?	Severity 1-10 1=no pain	When does it hurt? Constant, On and Off
1)							
2)							
3)							

Please mark all symptoms/conditions that are presently causing you a problem.

- ☐ Alcohol/drug abuse
- ☐ Allergies
- ☐ Aneurysm
- ☐ Arthritis
- ☐ Asthma
- ☐ Blurring of Vision
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold hands and/or feet
- ☐ Constipation
- ☐ Diabetes
- ☐ Diarrhea
- ☐ Digestive Problems
- ☐ Dizziness
- ☐ Do/did you play sports
- ☐ Do/did you smoke
- ☐ Fainting
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heartburn
- ☐ Hiatal Hernia
- ☐ High/low blood pressure
- ☐ Insomnia
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Lower back pain
- ☐ Menstrual Problems
- ☐ Numbness/Tingling in Arms or Legs
- ☐ Osteoporosis
- ☐ Problems urinating
- ☐ Respiratory Condition
- ☐ Ringing in ears
- ☐ Sinusitis
- ☐ Stroke
- ☐ Tendonitis
- ☐ Varicose Veins

Other health problems?____

____

Any family health conditions: Yes/No If yes please list:________________________________

____

Please list any medications you are currently taking and why?___________________________

____

Have you had this problem before? *Yes / No* Did it get better? *Yes / No*

How long did it take to get better? ____________ Have you received a diagnosis? ____________________

On a scale of 1 to 10 describe your stress level: (1=none) Occupational_____________Personal_____________

On a scale of Poor, Good, Excellent describe your:

Diet_____________ Exercise_____________ Sleep_____________ General Health_____________

Circle any tests you have had: X-ray, CT scan, MRI, Nerve scans, other ___________________________

Circle any types of care you have received in the past: Medical Care (drugs), Chiropractic Care, Physiotherapy, Acupuncture, Supplements (vitamins, herbs), other____

Have any of these helped you? *Yes / No* Which ones?______________________________________

____ *Signature*

_____________________ *Date*