SOUTH TRAIL CHIROPRACTIC
FAMILY WELLNESS CENTRE
Dr. Jeffrey P. Koep

Date:_____
Practice Member ID#
For Office Use Only

CONFIDENTIAL INFORMATION

Name: Mr. Mrs. Dr. Ms. Miss _____
First Initial Last

Address:_____
Street City Postal Code

Phone: (h)_____(w)_____(cell)_____AHC#_____Birth date:____/____/____
mm dd yyyy

Employer:_____Type of work:_____Name & number of emergency contact_____(p)_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Common Law

EMAIL_____ Opt IN ☐(This is used for office communication Eg: Appointment reminders & Office updates) Opt OUT ☐

Number of children and ages:_____Have they had a spinal checkup yet? ☐ Yes ☐ No

How did you hear about us? ☐ Live in Area ☐ Community Dinner ☐ Website ☐ Google ☐ **REFERRAL** _____

Your Health Profile

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, emotional and chemical stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced throughout your lifetime, allowing us to better assess the challenges to your health potential.

REASON FOR YOUR VISIT:_____HOW LONG HAVE YOU HAD THIS PROBLEM? _____

Physical Stresses

☐ Yes ☐ No Have you ever been involved in a motor vehicle accident (even if you were not injured)?
_____
☐ Yes ☐ No Have you had any falls or accidents (please list all)?
_____
☐ Yes ☐ No Have you had any falls or accidents as a child?
_____
☐ Yes ☐ No Do you currently play any sports? _____
☐ Yes ☐ No Have you had any sports injuries?
_____
☐ Yes ☐ No Have you had a concussion? _____
☐ Yes ☐ No Were you under regular Chiropractic care as a child?
☐ Yes ☐ No Does your job require lifting, repetitive motions, or excessive standing or sitting?
☐ Yes ☐ No Have you had any surgeries? _____

Chemical Stresses

☐ Yes ☐ No Do/did you smoke? How many/day? _____
☐ Yes ☐ No Do/did you drink alcohol? How many/week? _____
☐ Yes ☐ No Do you drink coffee? How many/day? _____
☐ Yes ☐ No Do you drink pop? How many/week? _____
☐ Yes ☐ No Do you eat out frequently or eat excessive amounts of junk food? _____
List any Drugs you are presently taking (prescription/non-prescription, otherwise):
_____

Emotional Stresses

On a scale from 1-10 (10 = worst) what is your current stress level?
Work?_____Home?_____Financial?_____Other? _____

Lifestyle:

On a scale of Very Poor, Poor, Good, Excellent, describe your:
DIET_____EXERCISE_____SLEEP_____GENERAL HEALTH_____

Addressing The Issues That Brought You To Our Office

If you have no symptoms or complaints, and are here for wellness services, please check here_____I Wish to Have Chiropractic Wellness Services. Others need to briefly describe the chief complaint, including the effect it has had on your life.

HAS THIS PROBLEM HAPPENED BEFORE? ☐ Yes ☐ No If YES, when and how many times_____

IF YOU ARE EXPERIENCING PAIN, IS IT… ☐ sharp ☐ dull ☐ achy ☐ pins & needles ☐ numb ☐ burning

SINCE THE PROBLEM STARTED, IS IT GETTING… ☐ worse ☐ better ☐ constant ☐ intermittent (comes & goes)

WHAT MAKES IT WORSE? ☐ sitting ☐ standing ☐ bending ☐ lifting ☐ walking ☐ other_____

WHAT MAKES IT BETTER? ☐ bed rest ☐ ice ☐ heat ☐ chiropractic ☐ medication ☐ other _____

HOW DOES THIS AFFECT THE FOLLOWING AREAS OF YOUR LIFE?
Family life_____Work_____Sports/Hobbies_____

Other doctors/therapists seen for this condition: ☐Yes,☐ No What type? _____

Is this condition work related? ☐ Yes ☐ No (we are not a WCB provider)

On a scale of 1 to 10 (10 being the highest) rate your commitment to correcting this problem? _____

Have you had previous chiropractic care? ☐ Yes ☐ No
Name of previous chiropractor_____How long ago? _____

CHECK ANY OF THE FOLLOWING YOU HAVE HAD, EVEN IF THEY DO NOT SEEM RELATED TO YOUR CURRENT PROBLEM

- ☐ High blood pressure
- ☐ Heart problems
- ☐ Chest pain
- ☐ Stroke
- ☐ Irregular heartbeat
- ☐ Gallbladder problems
- ☐ Vision problems
- ☐ Hearing problems
- ☐ Earaches
- ☐ Excessive thirst
- ☐ Vomiting
- ☐ Nervousness
- ☐ Headaches
- ☐ Fatigue
- ☐ Dizziness
- ☐ Cold/tingling arms/legs/hands/feet (circle)
- ☐ Poor/excessive appetite
- ☐ Ringing/buzzing in ear
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Mental disorder
- ☐ Anemia
- ☐ Stomach upset/gas/bloating
- ☐ Nausea
- ☐ Diarrhea/Constipation (circle)
- ☐ Walking problems
- ☐ Joint pain/stiffness
- ☐ Sleeping problems
- ☐ Loss of balance
- ☐ Depression
- ☐ Mood Swings
- ☐ Urination problems
- ☐ Bladder problems
- ☐ Menstrual irregularity/Cramps
- ☐ Hot Flashes
- ☐ Back pain
- ☐ Neck pain
- ☐ Eczema
- ☐ Arthritis
- ☐ Diabetes
- ☐ Clicking Jaw
- ☐ Asthma
- ☐ Irritability
- ☐ Fainting
- ☐ Cold sweats
- ☐ Allergies

FAMILY HISTORY –	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's Side	☐	☐	☐	☐	☐
Mother's Side	☐	☐	☐	☐	☐

Do you have health care benefits? ☐ Yes ☐ No

PLEASE READ THE FOLLOWING CAREFULLY

I understand and agree that health and/or accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and/or receipts to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment each visit unless arrangements have been made with this centre. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

SIGNATURE_____DATE_____