Help Us Understand Your Health & Wellness Goals

Old injuries, emotional tension, work and family situations along with poor dietary choices add to your daily stress load. This can cause muscles to overreact and joints within the spine to lock. However, our greatest concern is when those ongoing stressful habits affect the inner nerve connections, leaving you at risk for deeper health problems. Unwinding harmful spinal stress while coaching you towards a strong and vibrant lifestyle is what we love to do!

Name:_____ Date:_____

Address:_____ City:_____Postal Code:_____

Date of Birth:_____ Gender: Male___ Female___ Weight:_____ Height_____

Marital Status: M S W D CL Name of Spouse:_____ Number of Children:_____

Names of Parent/Guardians (if applicable):_____

Occupation:_____

Home Phone:_____-_____-_____ Bus:_____-_____-_____ Cell:_____-_____-_____

E-mail Address:_____

Referred by:_____

Have you ever seen a chiropractor before? Yes No If yes, who?_____

Name of family doctor? _____Date of last visit:_____

Childhood History (Age 0-15): Circle all that apply

Did you have any childhood illnesses?	Yes	No
Did you have any serious falls as a child?	Yes	No
Did you play youth sports?	Yes	No
Did you take medications?	Yes	No
Did you have surgery?	Yes	No
Have you fallen/jumped from a height over three feet?	Yes	No
Were you in any car accidents as a child?	Yes	No
Was there any prolonged use of medicine such as antibiotics or an inhaler?	Yes	No
Did you suffer any traumas (physical or emotional)	Yes	No
As a child, were you under regular chiropractic care?	Yes	No

Please share any additional information:

_____

Adult History (Age 16 to present)

Do/did you smoke?	Yes	No
Do/did you drink alcohol?	Yes	No
Have you been in any accidents (car, fall, sports)?	Yes	No
If yes, list here:		
Have you had any surgery?	Yes	No
If yes, list here:		
Have you had any fractures?	Yes	No
If yes, list here:		
Do/did you play adult sports?	Yes	No

Please rate the following:

Diet	Poor	Good	Excellent
Exercise	Poor	Good	Excellent
Type of exercise & frequency?			
Sleep	Poor	Good	Excellent
Hours per night?_____			
General health?	Poor	Good	Excellent

On a scale of 1 to 10, what is your stress level?
(1=none, 10=extreme)

Occupational:_____ Personal:_____

List any medications you are currently taking:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Adult History

Addressing issues that may have brought you to our office

Briefly explain what brought you to our office today:

_____
_____
_____
_____
_____
_____

Does this interfere with: □ Work □ Sleep □ Walking □ Hobbies □ Leisure □ Other

Have you see anyone else for this issue? Yes No

If yes, who?_____

If you have symptoms, please complete the following:

Where does it hurt?_____

_____

How long have you had this?_____

Have you ever had this before? Yes No

If yes, when?_____

Is the problem there: all the time comes & goes

Is the problem getting: worse same better

Does the pain travel to any other areas? Yes No

Describe how the pain feels:_____

_____

Any pain at night? Yes No

Does coughing, sneezing or straining aggravate the pain? Yes No

What makes it worse?_____

_____

_____

What makes it better?_____

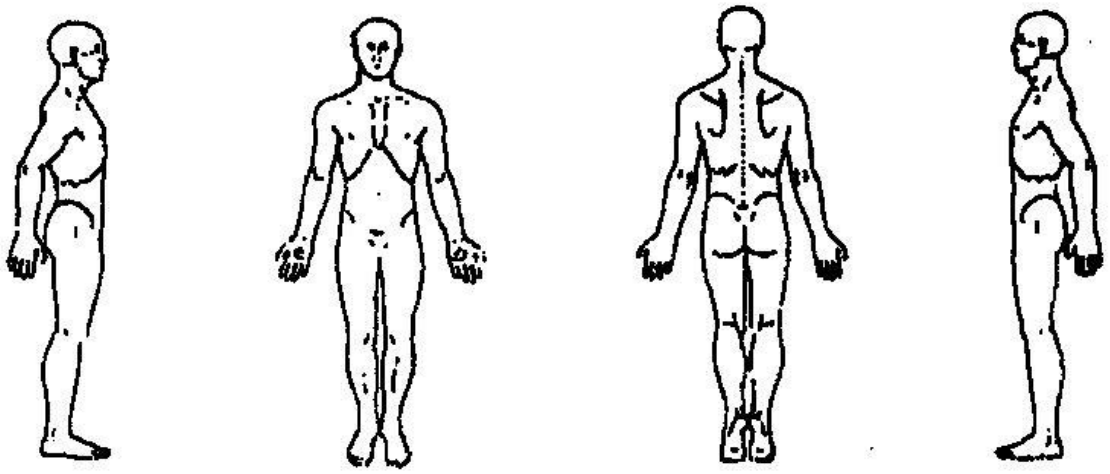
_____

_____

Adult History

Please use the body diagrams below to mark and describe each type of problem

Sharp/stabbing pain xxx	Dull ache ooo	Numbness …….
Tingling ******	Stiff/tight //////	Burning pain ++++++



Please check (✓) all symptoms <u>you have ever had</u>, even if they do not seem related to your current problem:

□ Headaches	□ Pins and needles in legs	□ Fainting	□ Neck pain
□ Pins and needles in arms	□ Loss of smell	□ Back pain	□ Loss of balance
□ Dizziness	□ Buzzing in ears	□ Ringing in ears	□ Nervousness
□ Numbness in fingers	□ Numbness in toes	□ Loss of taste	□ Stomach upset
□ Fatigue	□ Depression	□ Irritability	□ Tension
□ Sleeping problems	□ Stiff neck	□ Cold hands	□ Cold feet
□ Diarrhea	□ Constipation	□ Fever	□ Hot flashes
□ Cold sweats	□ Lights bother eyes	□ Urinary problem	□ Heartburn
□ Menstrual pain	□ Menstrual irregularity	□ Mood swings	□ Ulcers

Adult History

Family Health Profile

At our office, we are not only interested in your health and wellbeing but also that of your family and loved ones. Please list any health conditions or concerns you may have about your:

Children:_____
Spouse:_____
Mother:_____
Father:_____
Brother(s):_____
Sister(s):_____
Others:_____

What do you do for stress relief?

_____
_____
_____

Are there any other health habits that you could share with us?

_____
_____
_____

Imagine if you could transform your health, what would you choose to transform first?

I. _____
II. _____
III. _____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service.

Signature_____ Date:_____

*Signature of Parent or Guardian if under 16 years:_____

PATIENT PRIVACY CONSENT FORM

Privacy of your personal information is an important part of our office providing you with quality chiropractic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information.

In this office, Dr. Catherine Straus acts as the Privacy Information Officer.
All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information. In this consent form, we have outlined what our office is doing to ensure that:

- only necessary information is collected about you,
- we only share your information with your consent,
- storage, retention and destruction of your personal information complies with existing legislation and privacy protocols,
- our privacy protocols comply with privacy legislation, standards of our regulatory body, the Chiropractic College of Ontario and the law.

Do not hesitate to discuss our policies with Dr. Straus or any member of our staff. Please be assured that every staff member in our office is committed to ensuring that you receive the best quality Chiropractic Care.

HOW OUR OFFICE COLLECTS, USES AND DISCLOSES PATIENT'S PERSONAL INFORMATION

We are committed to collecting, using and disclosing your information responsibly and do so for the following purposes:

- To assess your health concerns, provide health care and advise you of treatment options.
- To establish and maintain contact with you.
- To remind you of upcoming appointments.
- To allow us to efficiently follow-up for treatment.
- To complete claims for insurance purposes.
- To validate visit dates and receipts upon your insurance company's inquiry.
- To invoice for goods and services.
- To process credit card payments.
- To collect unpaid accounts and follow-up on billing as required.
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others.

PATIENT CONSENT

I have reviewed the above information that explains how the Family Chiropractic and Wellness clinic will use my personal information and the steps that the clinic is taking to protect my information.

I, _____, agree that Family Chiropractic and Wellness can collect, use and disclose personal information as set out in the privacy policies above.

Signature:_____ Date:_____

*Signature of Parent or Guardian if under 16 years:_____