WHALE FAMILY CHIROPRACTIC

Dr. Robin Whale & Dr. Caroline Taylor

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GENERAL INFORMATION

Name:	DOB (D/M/Y):	Age:
Address:		
Cell Phone:	Alternate Phone:	
Email Address:	Can we text and/or email you? ☐ Yes ☐ No	

Occupation:	Employer:
Work Tasks (sitting, lifting, standing):	

Do you have children? ☐ Yes ☐ No If comfortable, please provide their names and ages below:

Emergency Contact Name:	Contact Number:
Relationship to you (parent, spouse):	

Who may we thank for referring you to this office?

HEALTH PROFILE

What brings you to our office today? _____

When and how did the problem occur? _____

If condition has occurred before, when? _____

Symptoms & Pattern: ☐ Sharp ☐ Dull ☐ Achy ☐ Pins & Needles ☐ Numb
☐ Constant ☐ Intermittent ☐ Occasional ☐ Cyclical

Provide a number between 1 and 10 that best describes the current severity of your discomfort: _____ (1 = MILD, 10 = SEVERE)

What make your symptoms feel worse? _____

_____

What makes your symptoms feel better? _____

_____

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Have you seen any other health care providers for these issues? If so, what form(s) of treatment (e.g. acupuncture, massage, physiotherapy, medication) and what were the results?

Are there other things you do personally to reduce discomfort or improve your general health (yoga, walking, stretching, sports)?

How is this condition affecting your ability to work and/or enjoy your free time?

What would you be doing if you felt your best again?

Who do you have as a personal support system for your health/goals, etc. (e.g. spouse, parent, friend)?

Have you ever been adjusted by a chiropractor before? ☐ Yes ☐ No If so, how often and for what length of time?

Results of chiropractic care (if applicable):

Have you had spinal x-rays taken within the last five years? ☐ Yes ☐ No If so, can a copy be provided to us? ☐ Yes ☐ No

Are there any other health concerns you would also like to discuss at this time?

What level of care are you seeking at this time?

- ☐ "Band-aid" Fix (just get rid of current symptoms)
- ☐ Corrective Care (aim to fix cause of symptoms)
- ☐ Wellness Care (improve overall health and vitality)

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SYSTEM CHALLENGES

Has your body communicated any of the following symptoms?

While it may seem unrelated to the purpose of your visit, this helps us with your overall assessment and care plan.

Check ☑ the *symptoms affecting you now*, and **add "P"** or **"R"** next to any issues you've had ***Previously*** *or* ***Repeatedly***

Nervous System
- ❑ Nervous ___
- ❑ Numbness ___
- ❑ Paralysis ___
- ❑ Dizziness ___
- ❑ Forgetfulness ___
- ❑ Confusion/Depression ___
- ❑ Fainting ___
- ❑ Convulsions ___
- ❑ Cold/Tingling Extremities ___
- ❑ Stress ___

Musculo-Skeletal
- ❑ Low Back Pain ___
- ❑ Pain Between Shoulders ___
- ❑ Neck Pain ___
- ❑ Leg Pain ___
- ❑ Arm Pain ___
- ❑ Joint Pain/Stiffness ___
- ❑ Walking Problems ___
- ❑ Difficult Chewing/Clicking Jaw ___
- ❑ General Stiffness ___

General
- ❑ Fatigue ___
- ❑ Allergies ___
- ❑ Loss of Sleep ___
- ❑ Fever ___
- ❑ Headaches/Migraines ___

Cardio-Vascular/Respiratory
- ❑ Chest Pain ___
- ❑ Stroke ___
- ❑ Blood Pressure Problems ___
- ❑ Irregular Heartbeat ___
- ❑ Heart Problems ___
- ❑ Lung Problems/Congestion ___
- ❑ Varicose Veins ___
- ❑ Ankle Swelling ___

EENT
- ❑ Vision Problems ___
- ❑ Dental Problems ___
- ❑ Sore Throat ___
- ❑ Ear Aches ___
- ❑ Hearing Difficulty ___
- ❑ Stuffed Nose ___

Gastro-Intestinal
- ❑ Poor/Excessive Appetite ___
- ❑ Excessive Thirst ___
- ❑ Frequent Nausea ___
- ❑ Vomiting ___
- ❑ Diarrhea or Constipation ___
- ❑ Heartburn ___
- ❑ Hemorrhoids ___
- ❑ Liver Problems ___
- ❑ Gall Bladder Problems ___
- ❑ Weight Trouble ___
- ❑ Abdominal Cramps/Bloat ___

FEMALES ONLY

Are you pregnant, or could you be?
- ❑ Yes
- ❑ No

When was your last period?

_____

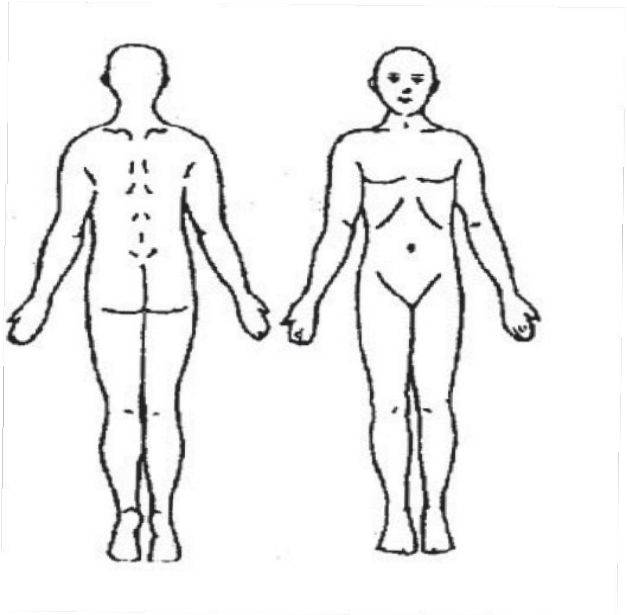
- ❑ Menstrual Irregularity
- ❑ Menstrual Cramping
- ❑ Vaginal Pain / Infections
- ❑ Breast Pain / Lumps

MALES ONLY
- ❑ Prostate Problems
- ❑ Sexual Dysfunction

Please indicate on the diagram to the right any area(s) of discomfort, including radiation of pain or numbness.

Circle = Aching
S = Sharp Pain
T = Tingling
R = Radiating
N = Numbness

NOTE: When using auto-fill PDF version of this form, this diagram will need to be completed by hand on the printed hard copy.



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STRESS PROFILE

The state of your body and health are a result of all that has happened to you up until this point in life. You face many physical, chemical and emotional stresses which your nervous system needs to integrate and adapt to. There are times when your body and nervous system have been overwhelmed by these stresses and your ability to thrive has been compromised. Details of your stressors throughout life will enhance our understanding of your current state of health.

**** Please provide details of Early Life and/or Adult (current) stressors, as applicable ****

PHYSICAL STRESSORS

Please describe the most significant physical stresses you have faced, starting in your childhood. These types of stresses can be short-term and traumatic, or longer-term and repetitive. For both time frames (early life and adult), list any serious accidents/falls/injuries, broken bones, surgeries, car/vehicle accidents, etc.

Early life examples: Difficult/C-section birth, significant or repeated falls as a child (from a height, down stairs, in sports), carrying a heavy backpack, sedentary lifestyle, extensive sitting (over 2 hours/day outside of school), slouching, demanding sports schedule.

Adult life examples: Commuting significant distance to work and/or a seated job, work injuries, job with very repetitive/one sided tasks, poor sleep, poor posture, lack of regular exercise, TV or technology usage for more than 2 hrs/day.

CHEMICAL STRESSORS

Please describe the chemical stressors your body has encountered.

Early life examples: Poor diet (didn't eat all food groups), high sugar/pop consumption, second-hand smoke, over-the-counter or prescription medication (inhalers, antibiotics, pain medication), low water consumption, alcohol and/or drug use at a young age.

Adult life examples: Smoking/vaping, poor diet (processed foods, no veggies, etc.), not drinking enough water, high-sugar use, artificial sweeteners (i.e. diet pop), excessive caffeine, regular alcohol/drug use, workplace exposure to chemicals/toxins.

STRESS PROFILE (Continued)

Please list your medications and what they are for:

Please list any vitamins/supplements you currently take:

EMOTIONAL/MENTAL STRESSORS

We face many emotionally stressful events in our lives, please list them below knowing they will be met without judgement.

Early life examples: Difficult/unstable home environment, divorce, emotional or other abuse, not allowed to express emotions, bullying, anxiousness/shyness, learning or school-related challenges.

Adult life examples: Marital issues/divorce, financial stresses, loneliness, depression/anxiety, perfectionist/control issues, illness (self or someone close to you), grief/loss, highly demanding career, parenting challenges, etc.

FAMILY HEALTH HISTORY

List any serious health conditions known in your immediate family history (parent, sibling, grand parent). For example: cancer, diabetes, heart disease, migraines, scoliosis, etc.

GOALS FOR OPTIMAL HEALTH

What are a few specific goals you could incorporate into your life at this time to improve your health? (e.g. drink more water, exercise more, remove avoidable stresses, etc.). Would you like help from us with accountability on these goals? ☐ Yes ☐ No