OAKTREE | CHIROPRACTIC ACUPUNCTURE CHINESE MEDICINE

Adult Chiropractic Health Form

PERSONAL INFORMATION

Name: _____ Gender: _____

Address: _____ City: _____ Postal Code: _____

Home #: _____ Cell #: _____ Office #: _____

Email: _____

☐ Yes ☐ No I consent to receiving email communication from Oaktree

(Emails we will send you include news updates from Oaktree. We will not spam you and you can unsubscribe at anytime. You will still receive appointment reminders and other important notices via email)

Birth date: [M]_____ [D]_____ [Y]_____ Age: _____ Weight: _____ Height: _____

MD name: _____

Workplace: _____ Occupation: _____

Referred by: _____

Marital Status: ☐ Single ☐ Common law ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Do you have kids? ☐ Yes (Ages: _____) ☐ No

CHIROPRACTIC HISTORY

Have you ever been to a chiropractor before? ☐ Yes ☐ No Were x-rays taken? ☐ Yes ☐ No

Name of Chiropractor: _____ City: _____

Date of last visit: [M]_____ [Y]_____ Duration & Frequency of Care: _____

I understand that the purpose of today's visit is to determine if I am a candidate for chiropractic care and that I am responsible for any fees agreed upon between myself and the attending doctor. All examination fees will be explained to me before any tests are performed.

_____ _____

Signature Date

PREVIOUS TRAUMAS

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MOTORIZED VEHICLE ACCIDENTS

Year:_____Description:_____

_____

Any injuries:_____

Year:_____Description:_____

_____

Any injuries:_____

FALLS & INJURIES (REGARDLESS OF AGE)

Falls from heights:_____

Falls down stairs:_____

Other falls:_____

Broken bones:_____

Childhood falls:_____

Other injuries:_____

POSTURE & HABITS:

- ☐ Sitting >6 hours/day
- ☐ Stomach sleeper
- ☐ Head forward posture
- ☐ Computer/phone >3 hours/day
- ☐ Activities that are repetitive in nature
- ☐ Serving or catering
- ☐ Crafting, etc
- ☐ Leaning or sitting on one hip
- ☐ Cross legs often
- ☐ _____

SPORTS & RECREATION:

Sports or recreation injuries:_____

_____

_____

Participation in High Impact Activities:

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

OCCUPATIONAL STRESSES

Occupation:_____

My job requires:

☐ Heavy lifting ☐ Awkward positions
☐ Repetitive stresses ☐ Sitting for long periods

Previous applicable occupation:_____

Tasks:_____

Work Injuries:_____

BIRTH TRAUMA

Was your own birth:

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

Have you ever given birth? Was it:

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

How many births have you had:_____

Commitment to Health:

Not committed at all — Somewhat committed — Highly committed

1 2 3 4 5 6 7 8 9 10

Overall Health:

Poor — Somewhat good — Excellent

1 2 3 4 5 6 7 8 9 10

HEALTH CONCERNS

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WHAT IS YOUR PRESENT PRIMARY HEALTH CONCERN?_____

Location:_____

How long have you had this condition?

Have you had a similar condition in the past?

What aggravates your condition?

What relieves your condition?

Are you getting pain or numbness in your arms or legs?
Details:_____

Is your condition getting progressively worse?
☐ Yes ☐ No ☐ It's constant ☐ It comes and goes

Pains are:
☐ Sharp ☐ Dull ☐ Burning ☐ Tightness

Pain severity (mark on line. 0=no pain, 10=severe)
Currently: 0.....10
At its worst: 0.....10

Other health care professionals who treated this condition? What else have you tried?

***What is this affecting that is MOST important in your life? (list all that apply)**

IF APPLICABLE, WHAT IS YOUR SECONDARY HEALTH CONCERN?

Location:_____

How long have you had this condition?

Have you had a similar condition in the past?

What aggravates your condition?

What relieves your condition?

Are you getting pain or numbness in your arms or legs?
Details:_____

Is your condition getting progressively worse?
☐ Yes ☐ No ☐ It's constant ☐ It comes and goes

Pains are:
☐ Sharp ☐ Dull ☐ Burning ☐ Tightness

Pain severity (mark on line. 0=no pain, 10=severe)
Currently: 0.....10
At its worst: 0.....10

Other health care professionals who treated this condition? What else have you tried?

What health goal, if you were to complete it or accomplish it, would have the greatest impact on your life?

CONDITIONS & SYMPTOMS

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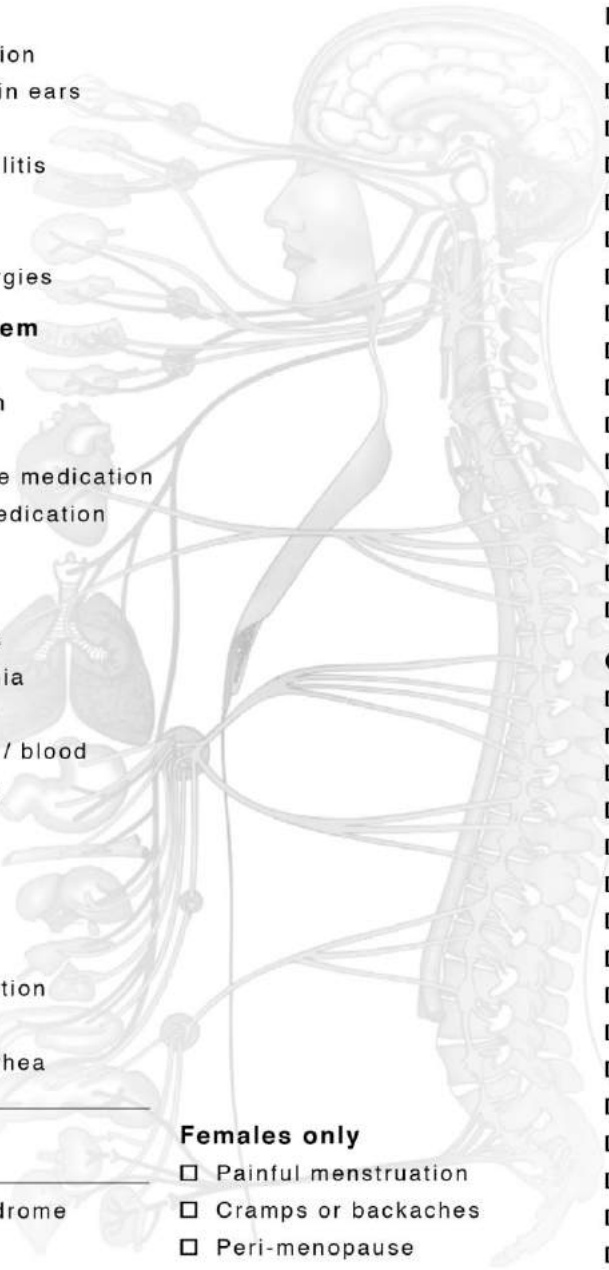
DID YOU KNOW EACH HEALTH CONCERN MAY RELATE TO A SPECIFIC AREA OF THE SPINE AND NERVOUS SYSTEM?
PLEASE CHECK OFF ANY BOXES BELOW THAT YOU ARE EXPERIENCING.



Head / Neck
- ☐ Blurred / failing vision
- ☐ Deafness / ringing in ears
- ☐ Earaches
- ☐ Sore Throat / tonsillitis
- ☐ Thyroid problems
- ☐ Sinus problems
- ☐ Environmental allergies

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
- ☐ Asthma

Digestive system
- ☐ Heartburn / indigestion
- ☐ Stomach cramps
- ☐ Constipation / diarrhea
- ☐ Food allergy: _____
- ☐ Food intolerances: _____
- ☐ Irritable bowel syndrome
- ☐ Crohn's disease
- ☐ Ulcers
- ☐ Belching / gas
- ☐ Nausea or vomiting
- ☐ Liver / gall bladder problems
- ☐ Colon trouble
- ☐ Black / bloody stool

Females only
- ☐ Painful menstruation
- ☐ Cramps or backaches
- ☐ Peri-menopause
- ☐ Passed menopause
- ☐ Currently pregnant: Y N
- ☐ Excessive / irregular flow
- ☐ Abnormal discharge
- ☐ Miscarriages # _____
- ☐ Date of last menstrual period _____

Musculoskeletal system
- ☐ Painful joints
- ☐ Painful muscles
- ☐ Tendinitis (location) _____
- ☐ Bursitis (location) _____
- ☐ Arthritis (location) _____
- ☐ Headaches / migraine
- ☐ Neck pain / stiffness
- ☐ Tension across shoulders, L R
- ☐ Numbness-tingling: arms/hands, L R
- ☐ Numbness-tingling: legs/feet, L R
- ☐ Mid-back pain / stiffness
- ☐ Lower-back pain / stiffness
- ☐ Scoliosis / spinal curvatures
- ☐ Faulty posture
- ☐ Painful tailbone
- ☐ Foot trouble, L R

General symptoms
- ☐ Fever / chills / sweats
- ☐ Frequent colds
- ☐ Fainting / dizziness
- ☐ Seizures / convulsions
- ☐ Skin problems
- ☐ Tremors
- ☐ Loss of balance
- ☐ Unexpected weight loss / gain
- ☐ Anemia
- ☐ Alcoholism
- ☐ HIV / AIDS
- ☐ Loss of sleep
- ☐ Poor memory / concentration
- ☐ Learning disability
- ☐ Irritable / nervous / tension
- ☐ Depression / emotional problems
- ☐ Anxiety
- ☐ Decreased energy / fatigue
- ☐ Tired / lethargic
- ☐ Autoimmune disease
- ☐ Antibiotic use
- ☐ Cancer: _____
- ☐ Other: _____

DISEASE CAUSATION ANALYSIS

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EXERCISE

How often do you participate in aerobic exercises? (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?

☐ Crossfit ☐ Gym ☐ Other:_____

How often do you stretch per week?

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

EMOTIONAL STRESS

Are you currently experiencing 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:_____

_____

EQUIPMENT

Mattress age:____ ☐ Comfortable ☐ Uncomfortable

Type: ☐ Coil ☐ Foam ☐ Rubber

Pillow: ☐ Ergonomic neck support ☐ Feather
☐ Foam ☐ Other:_____

Do you wear?: ☐ Custom orthotics
☐ Over the counter foot orthotics
☐ Foot lifts (height:_____)
☐ Heel lifts (height:_____)
☐ Over the counter foot supports

CHEMICAL STRESSES

Do you feel that you make healthy food choices?

☐ Yes ☐ No ☐ Don't know

How would you describe your nutrition?:_____

_____

Are you at your ideal body weight?

☐ Yes ☐ No ☐ Don't know

Do you take any supplements? ☐ Yes ☐ No

Which: ☐ Omega 3 ☐ Vitamin B ☐ Probiotics
☐ Vitamin D ☐ Multivitamin ☐ Iron
☐ Other:_____

Do you presently:

☐ Smoke ☐ Use recreational drugs
☐ Have a history of addiction (please explain)

_____

_____

Do you consume alcohol? ☐ Yes ☐ No

How often?

☐ 1-3 days/week ☐ Daily ☐ More than 1x per day

MEDICAL HISTORY

HEALTH CONDITIONS

Please list current diagnoses:_____

_____

_____

MEDICATIONS

Name and for which condition(s)?

_____

_____

_____

_____

SURGERIES

For what condition(s)? (include year preformed)

_____

_____

_____

_____

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

_____

_____

_____

_____