Dr. Barbara Sloat
Ancaster Cold Laser & Chiropractic Clinic
www.drbsloat.ca

286 Wilson Street East
Ancaster, Ontario L9G 2B9
905.304.8687
drbsloat@gmail.com

Clear Form

Your Health Profile

Date:

Personal Information:

Name: M F Other D.O.B: Age:

Address: City: Postal Code:

Telephone: Home Cell Health Card # Ver. Code:

E-mail address: Marital Status: M S D CL W

Employer: Occupation:

Address: Do you have Ext. Health Care? Y N Not sure

Spouse's Name if applicable: Parent's Name(if under 18):

No. of Children: Name(s): Referred by:

Have you had previous chiropractic care? Yes No When? With whom?

Medical Doctor: Date of last visit:

Are X-rays available? Y N Where?

The human body is designed to be healthy. Throughout life, events occur with damage your health expression. This form will help uncover the layers of damage, primarily to your nervous system, which have resulted in less than optimum health.

Following your chiropractic examination, we will outline a course of care to allow your body to begin correcting these layers of damage so you can recover your natural innate health potential.

Addressing the issue that brought you to our office:

If you have no symptoms or complaints, and are here for Wellness Services, please check here:

If you are symptomatic, please complete the following:

Where does it hurt:

How long have you had this? Have you had this before? Y N If yes, when?

Is the problem there: all the time? comes and goes? Is the problem getting: worse? No change? Better?

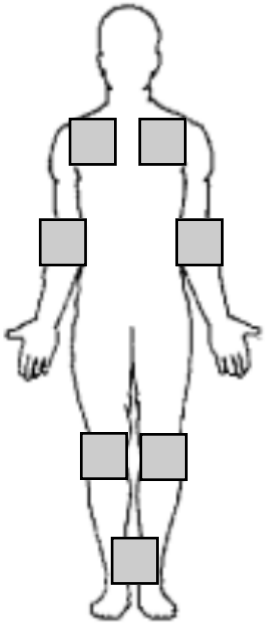
Does the pain travel anywhere?
Please describe how the pain feels:

Any pain at night? Y N Occasionally Does the pain affect the quality of your sleep? Y N

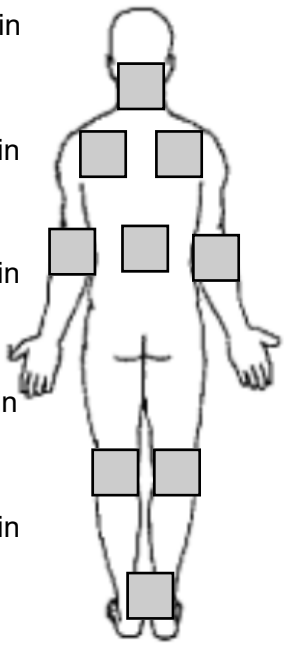
Does coughing, sneezing, or straining aggravate your pain? Y N

What makes it worse? What makes it better?

Please indicate the amount of pain/ discomfort associated with your problem(s):



Back	Select	No pain ○ ○ ○ ○ ○	Worst pain
Shoulder	Select	No pain ○ ○ ○ ○ ○	Worst pain
Elbow	Select	No pain ○ ○ ○ ○ ○	Worst pain
Knee	Select	No pain ○ ○ ○ ○ ○	Worst pain
Ankle	Select	No pain ○ ○ ○ ○ ○	Worst pain



Have you ever…?

Had an accident? (car, fall, sports, other) Y ○ N ○

If so, describe:

Had an operation? Y ○ N ○ Describe:

Had a fracture? Y ○ N ○ Describe:

Been hospitalized? Y ○ N ○ Describe:

Family History:	Back Pain	Headaches	Arthritis	Cancer	Heart	Diabetes
Mother	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

Please describe “other”:

Are you taking any of the following?

Anti-inflammatories(NSAIDs): ☐ Sedatives ☐ Muscle relaxants ☐ Antibiotics ☐

Aspirin/ analgesics ☐ Birth Control pills ☐ Insulin ☐ Antacids ☐

Vitamins/ herbs/ supplements ☐ If yes, please list: _____

Other: _____

Lifestyle profile:

Smoking: Y ◯ N ◯ If yes, # of cigarettes per day Alcohol: Y ◯ N ◯ If yes, # of drinks per day _____

Exercise: _____ times per week Sleep: _____ hours per day on back _____ on side _____ on stomach _____

Your stress level can be described as: minimal ◯ moderate ◯ severe ◯ intolerable ◯

Please check for any conditions past/present:

Past	Present	
☐	☐	headaches
☐	☐	fever
☐	☐	fainting dizziness
☐	☐	loss of sleep
☐	☐	loss of weight
☐	☐	convulsions
☐	☐	nervousness
☐	☐	poor concentration/memory

☐	☐	chest pain
☐	☐	high/low blood pressure
☐	☐	stroke
☐	☐	difficulty breathing
☐	☐	chronic cough

☐	☐	nausea
☐	☐	vomiting
☐	☐	heartburn
☐	☐	ulcer
☐	☐	belching or gas

Past	Present	
☐	☐	neck pain/ stiffness
☐	☐	back pain
☐	☐	pain between shoulder
☐	☐	pain or numbness in arms,
☐	☐	hands, legs, feet
☐	☐	bursitis
☐	☐	arthritis
☐	☐	swollen feet
☐	☐	spinal curvature

☐	☐	appetite changes
☐	☐	excessive thirst
☐	☐	constipation/diarrhea
☐	☐	jaundice
☐	☐	gall bladder trouble
☐	☐	colitis
☐	☐	hemorrhoids
☐	☐	black/bloody stools
☐	☐	changes in bowel or bladder habits
☐	☐	thyroid problems

Past	Present	
☐	☐	blurred/failing vision
☐	☐	deafness
☐	☐	earaches
☐	☐	sore throat
☐	☐	hoarseness
☐	☐	difficulty swallowing
☐	☐	frequent colds
☐	☐	sinus infections
☐	☐	asthma
☐	☐	allergies
☐	☐	kidney infections/stones
☐	☐	problems with urination
☐	☐	blood in urine
☐	☐	bed wetting

☐	☐	infertility
☐	☐	sexual dysfunction

Women Only:

☐	☐	excessive menstruation
☐	☐	irregular cycle
☐	☐	hot flashes
☐	☐	breast pain/lumps

Conditions:

☐ osteoporosis ☐ fibromyalgia ☐ eczema/skin problems ☐ diabetes

☐ other (please specify)

_____

Are you wearing:

☐ heel lifts ☐ sole lifts ☐ inner soles ☐ arch supports ☐ orthotics

What do you hope to do better and enjoy more as a result of the improved health you will gain from Chiropractic care?

Signature

Date

People go to a Chiropractor for a variety of reasons. Please indicate the type of care desired so that we may be guided by your wishes whenever possible.

☐ Preventative Care - *I want my body to be brought to the highest state of health possible with Chiropractic care.*

☐ Corrective Care - *I want to have the cause of the problem as well as the symptoms corrected and relieved*

☐ Relief Care - *I want symptomatic relief of this condition only*