

**356 Wilson Street East
Ancaster, ON L9G 2C2**

Referred by: _____

Our purpose is to improve your Function and Quality of Life. Everyday, we experience Stressors in our life that can accumulate and result in the loss of normal function. By answering the following questions, we can assess the challenges these Lifestyle Stressors have on your quality of life.

	Yes	No	Unsure
Did you have any childhood illnesses?			
Was there prolonged use of medicine such as antibiotics or an inhaler?			
Did you have any surgery?			
Did you have any serious falls or jumps as a child?			
Were you involved in any car accidents?			
Did you suffer any trauma (physical or emotional)?			
Did you play youth sports?			
As a child, were you under regular Chiropractic care?			

What brings you to Malpass Family Chiropractic (your health concerns)?

THE ADULT YEARS (16 to Present)

Health Concerns (Please list according to severity)

How long have you
had this condition?

Is it
Better? Worse? Comes & Goes?

1. _____

2. _____

3. _____

4. _____

Is it interfering with any of the following?

Work _____

Sleep _____

Daily Routine _____

Sports/Exercise _____

Other (please explain) _____

List any accidents, falls and/or injuries _____

List any surgeries _____

List any medication, vitamins or nutritional supplements _____

Do you wear orthotics? ____ Yes ____ No

Other Doctors seen for this? ____ Yes ____ No Who/When? _____

Previous Chiropractic care? ____ Yes ____ No Who/When? _____

Family Doctor: _____ Dentist: _____

Please list any Lifestyle Stressors you have had:

1. Physical stress (falls, accidents, work posture, etc.) _____

2. Biochemical/environmental stress (smoke, drugs, alcohol, unhealthy diet, etc.) _____

3. Mental/emotional stress (work, relationships, finances, etc.) _____

On a scale of Poor, Good, Excellent, describe your:

Diet _____

Exercise _____

Type of Exercise _____

Sleep _____

How do you sleep?

Back _____

Side _____

Stomach _____

Rate your Present level of Stress:

Very Low

Very High

Please **Check** all Symptoms you have ever had, even if they do not seem related to your current condition:

_____Headaches	_____Sleep Problems	_____Pins and Needles in Leg
_____Neck Pain or Stiffness	_____Heartburn	_____Numbness in Toes
_____Pins and Needles in Arm	_____Shortness of Breath	_____Constipation
_____Numbness in Fingers	_____Chest Pain	_____Diarrhea
_____Dizziness	_____Stomach Upset	_____Problem Urinating
_____Loss of Balance	_____Pain Between Shoulder Blades	_____Menstrual Pain or Irregularity
_____Buzzing or Ringing in Ears	_____Fatigue	_____Cold Hands
_____Sinus Problems	_____Low Back Pain	_____Cold Feet
_____Irritability	_____Tension	

FAMILY HISTORY

	Heart Disease	Arthritis	Cancer	Diabetes	Other:
Father's Side	_____	_____	_____	_____	_____
Mother's Side	_____	_____	_____	_____	_____

WOMEN ONLY

Date of Last Menstrual Cycle (Start): _____

No possibility of Pregnancy Due to:

Abstinence_____	Birth Control Pill _____
I.U.D._____	Other_____