PERSONAL HEALTH PROFILE

CHIROPRACTIC FIRST
Natural Health Group

Date:	First Name:		Last Name:		
Home Address:			City:	Postal Code:	
Primary Email Address:			Alternative Email Address:		
Home Phone: ( )		Work Phone: ( )		Cell Phone: ( )	
Gender: ☐M ☐F	Date of Birth: DD: MM: YY:	Age	Height: feet, Inches	Weight: Pounds	Family Physician Name: _____ Phone: _____ Date of last visit: _____
Marital Status: ☐ Single ☐ Married ☐ Common law ☐ Widowed ☐ Separated ☐ Divorced					Occupation:
Spouse/Partner's Name:					Employer:
Spouse/Partner's Cell Phone:					Extended Health Insurance (EHI): ☐ No ☐ Yes Company: _____
Do you have children? ☐ No ☐ Yes What are your children's names/ages?					EHI $ Participation / Year: _____ Is this amount ☐ per person or ☐ for the entire family?
					EHI Renewal Date:
If you are under 18, what are your Parents' names?					Which patient referred you to our office? _____ Other referral source: _____

Present State of Health

➢ What made you decide to take action on this issue today?

_____

	Primary concern	Secondary concern
Specific concern(s) and location		
How long have you had this?		
How would you describe the concern?	❒ Sharp ❒ Dull/achy ❒ Burn ❒ Pins/needles	❒ Sharp ❒ Dull/achy ❒ Burn ❒ Pins/needles
How often does this happen?	❒ Constant ❒ Intermittent ❒ Daily ❒ Weekly ❒ Monthly ❒ _____	❒ Constant ❒ Intermittent ❒ Daily ❒ Weekly ❒ Monthly ❒ _____
What makes it worse? (sitting, standing etc)		
What have you tried to address this concern?		

How does this problem affect your mood, energy, or ability to enjoy life?		
What specific activity or part of life is most affected by this issue?	❒ Ability to work ❒ Hobbies/sports ❒ Family/social time ❒ Sleep ❒ Daily activities ❒ Other_____ _____ _____	❒ Ability to work ❒ Hobbies/sports ❒ Family/social time ❒ Sleep ❒ Daily activities ❒ Other_____ _____ _____
If this issue was resolved, what would you do more of?		

- If your insurance doesn't fully cover care, would you still want to fix this? ☐ No ☐ Yes
- Will you need to speak with anyone before making a health decision? ☐ No ☐ Yes
- What approaches have you already tried (chiro, physio, massage, medication)?

  _____
- Why do you think it DID NOT work or DID NOT LAST?

  _____

Health History

Trauma and Stresses		Office Use
Automobile Accident(s) - Only 10km/h is needed to cause nerve and spinal damage. 1. Date:_____ ❒ Driver ❒ Passenger Impact Speed_____km/h, Site of Impact ❒ Front End ❒ Read End ❒ Side Swipe ❒ T-Bone What impacted the car? ❒ Car(s) ❒ Person ❒ Other_____ Symptoms_____ ❒ Seatbelt ❒ Air Bag Deployed Spine checked by Chiropractor after accident ❒ Yes ❒ No 2. Date:_____ ❒ Driver ❒ Passenger Impact Speed_____km/h, Site of Impact ❒ Front End ❒ Read End ❒ Side Swipe ❒ T-Bone What impacted the car? ❒ Car(s) ❒ Person ❒ Other_____ Symptoms_____ ❒ Seatbelt ❒ Air Bag Deployed Spine checked by Chiropractor after accident ❒ Yes ❒ No		
Have you fractured any bones in your body? Which bones and when?		
Falls, Impacts, Injuries from Hobbies and Sports:		
How many hours per day do you spend: Sitting at work_____ Standing at work_____ Lifting/Carrying _____	Year(s) at job with similar postures (sitting, standing, lifting)	
How many hours per day do you use the following: Computer _____ Smart Phone _____ Tablet _____		
How many hours per day do you spend: Sitting at home_____ Standing at home_____		
On average, how many hours do you sleep per night?_____ Do you sleep on your ❒ Back ❒ Side ❒ Front? (Check all that apply) ❒ Difficulty falling asleep ❒ Difficulty staying asleep How many times do you wake up per night_____		
Have you ever been hospitalized? If so, please describe:		

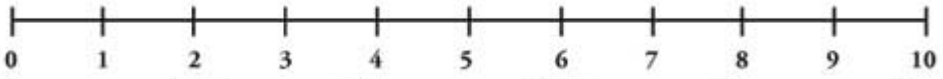
What surgeries have you had? (type and date)

What medications have you taken in the last 5 years?
❒ Blood Pressure ❒ Cholesterol ❒ Pain Killers ❒ Antidepressants ❒ Antihistamines ❒ Inhaler
❒ Other _____

What chemicals/toxins have you been exposed to:
❒ Alcohol ❒ Tobacco (First or Secondhand) ❒ Marijuana ❒ Work/Home Pollution_____
❒ Mercury Tooth Fillings ❒ Other_____

Rate your mental/emotional stress level from 0 to 10 on the scale below:

No Stress Moderate Stress High Stress



What is causing your stress ❒ Work ❒ Home ❒ Family ❒ Other_____

Family Health History

Many health concerns are related through family members. What health concerns has your family experienced?

Children: _____ Spouse/Partner: _____ Parents: _____
_____ _____ _____
_____ _____ _____

For Doctors Use

Verbal Consent Given for Exam_____

Balance (kg)	Cervical Rot. Left (80)	Cervical Rot. Right (80)	Cervical Flexion (65)	Cervical Ext. (50)	Cervical Lat. Flex Left (45)	Cervical Lat. Flex. Rt. (45)	Lumbar Flex. (90)	Lumbar Ext. (30)	Other	Other
L R Even										

Palpation

OC	C1	C2	C3	C4	C5	C6	C7	T1	T2	T3	T4	T5	T6	T7	T8	T9	T 10	T 11	T 12	L1	L2	L3	L4	L5	S X	L SI	R SI	C X

Other