Elora Chiropractic
(519) 846-0444
1-58 Wellngton Road 7
Elora ON N0B 1S0

It's time to live your life by DESIGN

YOUR CONFIDENTIAL HEALTH PROFILE

Patient #: ______________________ Date: ______________________

PERSONAL INFORMATION

How do you wish to be addressed in our office? ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss. ☐ Dr.

Name: ______________ Date of birth: ______________ ☐ Male ☐ Female

Street address: ______________________________

City: ______________ Province: ______________ Postal code: ______________

Home phone: ______________ Work: ______________ Mobile: ______________

E-mail address: ______________________________

Occupation: ______________________ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse / partner's name: ______________________________

Children's names & ages: ______________________________

Previous Chiropractor / RMT: ______________________ Last visit: ______________

How did you hear about our office? ______________________________

What are your hobbies: ______________________________

Please mark an "X" where you believe your health is and an "O" where you would like to be.

0-59 Very Challenged	60-69 Challenged	70-79 Transition	80-89 Good	90-100 Excellent
☐	☐	☐	☐	☐

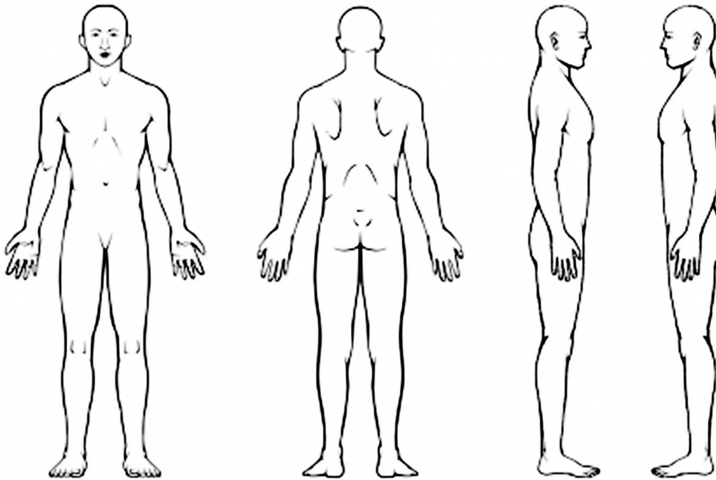
The following is for professional use only. Please continue on the next page.

Health objectives:
☐ Temporary relief only ☐ Correction and prevention ☐ Optimal health

CURRENT HEALTH PROFILE

Health concerns: *list according to severity*	Severity: *1=mild, 10=worst*	When: *did this episode start?*	Previous history: *dates of previous episodes*	Symptons: *constant or intermittent*

Using the appropriate letter from the legend below, please mark any and all areas where you feel pain, numbness, spasm, tenderness or any other sensation that is unusual or abnormal:



Aching – AA	Sharp – SP
Burning – BB	Shooting – SH
Cramps – CC	Stabbing – SB
Dull – DD	Stiffness – ST
Muscle Spasm – MM	Swelling – SW
Numbness – NN	Throbbing – TT
Pins & Needles - PN	Tenderness – TN

Please briefly describe your chief concern, including the effect it has had on your life:

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Does the pain travel / radiate anywhere? ☐ No ☐ Yes (please describe): ____________________

Since the problem started, is it: ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse? ____

What have you done that has helped you feel better? ______________________________

What have you done for it that was of NO help? ______________________________

Is this condition interfering with your: ☐ Work ☐ Sleep ☐ Exercise / Walking / Sports ☐ Hobbies

☐ Positive mental attitude ☐ Other (please specify) ______________________________

Other health care professionals seen for this condition:

Name / Profession:	Date:	Diagnosis:	Treatment:	Results:

Were X-Rays taken? ☐ No ☐ Yes (area of body): ________________ Date: ______________________

Current medications: ____

GENERAL HEALTH PROFILE

Check all symptoms you have ever had, even if they do not seem related to your current problem:

☐ Neck pain	☐ Pins & needles / Arms	☐ Low back pain	☐ Allergies
☐ Headaches	☐ Numbness in fingers	☐ Pins & needles / Legs	☐ Loss of smell
☐ Light bothers eyes	☐ Shoulder pain	☐ Numbness in toes	☐ Loss of taste
☐ Dizziness	☐ Mid back pain	☐ Loss of balance	☐ Sinus trouble
☐ Fainting	☐ Chest pain	☐ Urinary problem	☐ Fatigue
☐ Loss of concentration	☐ Heartburn	☐ Foot trouble	☐ Cold sweats
☐ Buzzing in ears	☐ Difficulty breathing	☐ Stomach upset	☐ Hot flashes
☐ Earache	☐ Sleeping problems	☐ Constipation	☐ Depression
☐ Nervousness	☐ Cold hands	☐ Diarrhea	☐ Irritability
☐ Tension	☐ Cold feet	☐ Skin conditions	☐ Mood swings
Women only:	☐ Menstrual pain	☐ PMS	☐ Pregnant

FAMILY HEALTH PROFILE

Please list any health conditions or concerns that your immediate family may have:

Mother: ______________________________ Father: ______________________________

Brothers/Sisters: ____

Children: ______________________________ Spouse: ______________________________

WHAT DO YOU WANT?

If we were meeting here 1 year from today – and you were looking back over that year, what has to have happened during that period concerning your health, for you to feel happy about your progress?

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What are the 3 biggest things holding you back from achieving the level of health you want?

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STRESS PROFILE

Chronic physical, chemical and emotional stress is the cause of most health problems. Review these common stresses and check when you experienced it in your life. Check P for past or C for current. Your answers will help us to determine what has contributed to your present health.

Physical Stress: (please explain as necessary)

☐ P ☐ C Forceps, suction extraction, or cesarean delivery: ____________________

☐ P ☐ C Accidents (auto, work related, falls or other): ____________________

☐ P ☐ C Surgical operations: ____________________

☐ P ☐ C Strains, sprains, and / or broken bones: ____________________

☐ P ☐ C Poor posture (excessive computer work, driving): ____________________

☐ P ☐ C Poor sleeping habits: ____________________

☐ P ☐ C Repetitive movements: ____________________

☐ P ☐ C Sports injuries: ____________________

☐ P ☐ C Heavy lifting and / or bending: ____________________

☐ P ☐ C Overweight: ____________________

☐ P ☐ C Lack of exercise: ____________________

Chemical Stress:

☐ P ☐ C Prescription or over-the-counter medication: ____________________

☐ P ☐ C Consume alcohol: ____________________

☐ P ☐ C Consume caffeine (coffee, tea, pop): ____________________

☐ P ☐ C Use tobacco products: ____________________

☐ P ☐ C Use artificial sweeteners (aspartame, sucralose): ____________________

☐ P ☐ C Poor diet (fast food, white flour, white sugar): ____________________

☐ P ☐ C Environmental pollution: ____________________

☐ P ☐ C Overweight: ____________________

Emotional Stress:

☐ P ☐ C Divorce of parents or spouse: ____________________

☐ P ☐ C Death of a loved one: ____________________

☐ P ☐ C Serious illness (self or a loved one): ____________________

☐ P ☐ C Financial concerns: ____________________

☐ P ☐ C Procrastination: ____________________

☐ P ☐ C Worry and / or fear: ____________________

☐ P ☐ C Work environment: ____________________

☐ P ☐ C Relationships: ____________________

☐ P ☐ C Anger by you or at you: ____________________

☐ P ☐ C Low self-esteem: ____________________

Our goal is to provide the safest and most effective care possible. In order to do so, it is important that we perform a series of tests. I consent to a complete examination as the doctor deems necessary.

Signature: ____________________ Date: ____________________