



PERSONAL HEALTH PROFILE

Name:			Date:		
Home Address:			City:		Postal Code:
E-mail Address:			Home Phone: ()		Work Phone: ()
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Common law <input type="checkbox"/> Widowed		Cell Phone: ()		
Date of Birth: MM DD YY		Age:	Occupation:		Employer:
Work address:			City:		Postal Code:
Extended Health Insurance: <input type="checkbox"/> No <input type="checkbox"/> Yes Company:		\$ Participation / Year:		Renewal Date (i.e. Jan 1):	
How were you referred to our office?		Have you ever received chiropractic care before? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of last visit? Who was the Doctor? Years under care? Where was the Doctor?			
Spouse's Name:		Spouse's Occupation:			
Do you have children? <input type="checkbox"/> No <input type="checkbox"/> Yes	What are your children's names/ages?		If you are under 18, what are your Parents' names?		

Present state of health

Years of continuing damage show up as acute or chronic symptoms.

Is this visit for a wellness checkup? yes no . If this is for a specific concern, proceed below:

	Primary concern	Secondary concern
Specific concern(s) and location		
How long have you had this?		
How would you describe the pain?	<input type="checkbox"/> sharp <input type="checkbox"/> dull/achy <input type="checkbox"/> burn <input type="checkbox"/> pins/needles	<input type="checkbox"/> sharp <input type="checkbox"/> dull/achy <input type="checkbox"/> burn <input type="checkbox"/> pins/needles
How often does this happen?	<input type="checkbox"/> constant <input type="checkbox"/> on/off <input type="checkbox"/> daily	<input type="checkbox"/> constant <input type="checkbox"/> on/off
What makes it worse? (sitting, standing etc)		
What have you tried to address this concern?		
At its worst, this problem interferes with:	<input type="checkbox"/> ability to work <input type="checkbox"/> hobbies/sports <input type="checkbox"/> family/social time <input type="checkbox"/> sleep <input type="checkbox"/> daily activities	<input type="checkbox"/> ability to work <input type="checkbox"/> hobbies/sports <input type="checkbox"/> family/social time <input type="checkbox"/> sleep <input type="checkbox"/> daily activities

Check off any of the following bodily warning signs that apply to you.
If you have experienced them in the past, please circle them.

- | | | |
|--|--|--|
| <input type="checkbox"/> Tension/Headaches | <input type="checkbox"/> Deafness/Ears Ringing | <input type="checkbox"/> Bladder Problems |
| <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Earaches/Ear infections | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Weight Trouble |
| <input type="checkbox"/> Tension Across Top of Shoulders | <input type="checkbox"/> Numbing/Tingling in Legs/Feet | <input type="checkbox"/> Breathing Problems |
| <input type="checkbox"/> Pain Between Shoulders | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Numbing/Tingling in Arms/Hands | <input type="checkbox"/> Iliotibial Band Syndrome | <input type="checkbox"/> Immune Problems |
| <input type="checkbox"/> Wrist/Hand pain | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Frequent Colds/Flu |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Shin Splints | <input type="checkbox"/> Difficulty Sleeping |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Arthritis/Swollen Joints | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Elevated cholesterol | <input type="checkbox"/> Allergies / Infections | <input type="checkbox"/> Poor Concentration/Memory |
| <input type="checkbox"/> Poor Posture | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Sexual Dysfunction |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Blurred/Failing Vision | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |

Other Health Concerns: _____

Women Only:

- | | | |
|--|--|---|
| <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Irregular Cycle | <input type="checkbox"/> Date of last menstrual period: ___ / ___ / ___ |
| <input type="checkbox"/> Excessive Cramping/Pain | <input type="checkbox"/> Hot Flashes | |
| <input type="checkbox"/> Excessive Menstruation | <input type="checkbox"/> Breast Pain/Lumps | |

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

Children: _____ Spouse/Partner: _____ Parents: _____

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TERMS OF ACCEPTANCE

When a person seeks chiropractic health care and when a chiropractor accepts a person for such care, it is essential that both are speaking and working for the same goal. Chiropractic does NOT treat diseases or symptoms. Chiropractic has only one goal:

TO LOCATE, ANALYZE, AND CORRECT

SPINAL INTERFERENCE TO THE NERVOUS SYSTEM

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function in the body. The **SUBLUXATION** (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the **INNATE** healing power of the body to work at maximum efficiency to restore, maintain, and promote health.

I hereby request and consent to the performance of chiropractic procedures including diagnostic x-rays, if necessary, on me by the doctor and/or anyone working in this clinic authorized by the doctor.

I will have an opportunity to discuss with the doctor and/or staff, the nature and purpose of chiropractic adjustments and other procedures, as well as any questions I have regarding specific technique performed. I understand that the results expected are not guaranteed, as every person is unique.

I further understand and am informed that, as in all health care, in the practice of manipulation by medical doctors, physiotherapists and chiropractors there are some very slight and minimal risks to care, including, but not limited to: minor muscle strains and sprains, rib fractures, disc injuries and cerebral vascular accidents (CVA). The best current scientific evidence shows that the risk of serious injury or death from aspirin is 1 in 2500; the risk of cerebral vascular accident (CVA) from oral contraceptives is 1 in 25,000; the risk of CVA in the general population is 1 in 175,000; the risk of CVA from manipulation is 1 in 5,850,000. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure, which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read the above consent. I will have an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of present and future 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.

TO BE COMPLETED BY PATIENT:

SIGNATURE OF PATIENT
(OR PARENT/GUARDIAN)

PRINT PATIENT'S NAME

DATE SIGNED

WITNESS

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