

Last Name:.....First Name:.....  
 Mail Address:..... Residential Address:.....  
 Mobile Phone:.....Home Phone:..... Work Phone:.....  
 Occupation:..... Employer:.....  
 Email: ..... Date of Birth(d/m/y): .....  
 Age:..... Spouse's Name: .....  
 Spouse's Name:.....  
 Names and Ages of children:.....  
 .....  
 Whom may we thank for telling you about us?.....

**Health Information**

What are your objectives in consulting our centre?.....  
 .....  
 What are your health goals once these objectives have been met?.....  
 .....  
 Who was the last doctor who created a health development plan for you?.....  
 Did you follow the Doctor's recommendations? Yes  No   
 How long were you able to stay on the health development plan?.....  
 What were your results?.....  
 Do you have X-rays ? Yes  No   
 List previous surgeries & dates?.....  
 Have you had previous Chiropractic Care ? Yes  No  when.....  
 Chiropractor's name?.....  
 Are you healthier today than you were five years ago ? Yes  No   
 Will you be healthier five years from now than you are today ago ? Yes  No

**Lifestyle Information**

Do you exercise regularly? Yes  No  if yes, how much and how often?.....  
 Do you smoke? Yes  No  if yes, how much and how often?.....  
 Do you consume alcohol? Yes  No  if yes, how much and how often?.....  
 Do you drink adequate amount of water? Yes  No  if yes, how much per day?.....  
 List your hobbies?.....

## Health History

Please check all the following health concerns that you have experienced, even if you do not think that your answers relate to our present health condition.

Allergies	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	Immune system Disorder	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Infertility	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	Menstrual Cramps	<input type="checkbox"/>
Bladder Problems	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>
Circulatory/ Vascular Disorder	<input type="checkbox"/>	Numbness/Tingling	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>
Digestive Problems	<input type="checkbox"/>	Skin Conditions	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	Spondylosis	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Heartburn/Reflux	<input type="checkbox"/>	Urinary difficulty	<input type="checkbox"/>

Other: .....

## Stress History

Please indicate whether you have ever experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to your present health concerns.

	Childhood	Adulthood
Repeated/prolonged Antibiotic use	<input type="checkbox"/>	<input type="checkbox"/>
Inhaler use	<input type="checkbox"/>	<input type="checkbox"/>
Car Accident	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Medications	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Vaccination	<input type="checkbox"/>	<input type="checkbox"/>
Head Trauma	<input type="checkbox"/>	<input type="checkbox"/>
Contact Sports	<input type="checkbox"/>	<input type="checkbox"/>
Fall/Jump from a height 3 feet	<input type="checkbox"/>	<input type="checkbox"/>
Workplace Stress	<input type="checkbox"/>	<input type="checkbox"/>
Childhood Illness	<input type="checkbox"/>	<input type="checkbox"/>

Other Traumas?(Physical or emotional) .....

Which best describes your reason for consulting our office?

I have specific concern and require help with this concern.

I want to ensure that my health concerns do not become an ongoing problem that will impact my future Health

I want to be healthier 5 years from now than I am today.