



Personal Information

Name _____ Date _____

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

Address _____ City _____ Province _____

Postal Code _____ Date of Birth: D__ M __ Y _____ Age _____

Home Phone _____ Cell Phone _____ E-mail _____

Where do you prefer to be contacted? Home ___ Work ___ Cell ___

Business/Employer _____ Business Ph. _____ Ext. _____

Type of work _____

Marital Status: Single/Married /Partner /Divorced /Widowed Spouse's Name _____

Do you have children? Y N Names/Ages of Children: _____

Are you pregnant? Y N Weeks _____

Whom may we thank for referring you to Vibrant Life Chiropractic? _____

Check the phrase that most represents your reason for care:

0 Wellness 0 Prevention 0 Feel good 0 Symptom Relief

Health Concerns

(If there are no current concerns and this assessment is to ensure optimum health and functioning, skip to next page)

Concern	Severity 1=mild 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is the symptom present?

Is this condition interfering with your:

0 Work 0 Family 0 Sleep 0 Daily Routine 0 Sports/Activities

Other: _____

What have you done for this condition? Was it of benefit? _____

Often seemingly unrelated symptoms can tell us information about the function of the nervous system and overall health:

(Please check if you have had any of the following – past or present)

- | | | |
|--|--|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> bloating/gas |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> asthma | <input type="checkbox"/> upper back pain |
| <input type="checkbox"/> fainting | <input type="checkbox"/> urinary problems | <input type="checkbox"/> neck pain |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> constipation | <input type="checkbox"/> low back pain |
| <input type="checkbox"/> irritability | <input type="checkbox"/> diarrhea | <input type="checkbox"/> radiating pain |
| <input type="checkbox"/> depression | <input type="checkbox"/> weight loss | <input type="checkbox"/> stiffness |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> weight gain | <input type="checkbox"/> reduced mobility |
| <input type="checkbox"/> loss of concentration | <input type="checkbox"/> fevers | <input type="checkbox"/> numbness in leg(s) |
| <input type="checkbox"/> loss of memory | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> numbness in feet |
| <input type="checkbox"/> poor coordination | <input type="checkbox"/> frequent colds | <input type="checkbox"/> numbness in hand(s) |
| <input type="checkbox"/> vision changes | <input type="checkbox"/> sinus congestion | <input type="checkbox"/> weakness |
| <input type="checkbox"/> ears buzzing | <input type="checkbox"/> sore throats | <input type="checkbox"/> muscle cramps |
| <input type="checkbox"/> loss of smell | <input type="checkbox"/> ear pain/infections | <input type="checkbox"/> sleeping problems |
| <input type="checkbox"/> loss of taste | <input type="checkbox"/> allergies | |

Other: _____

Do any of your family members have any of the following health conditions?

- Heart Disease Diabetes Cancer Depression Stroke Arthritis Hypertension

Please specify their relationship to you: _____

What other health practitioners you have seen? (Mark P for past or C for current)

- 0 Chiropractor 0 Medical doctor 0 Naturopath 0 Physiotherapist 0 Massage therapist

Other _____

Compared to five years ago are you now: 0 Not as Healthy 0 As Healthy 0 Healthier

What Strategies have you used? _____

5 years from now will you be: 0 Not as healthy 0 As Healthy 0 Healthier

What additional strategies will you have to use to get different results? _____

PHYSICAL HISTORY

Birth Stress – Do you have any information about your birth history: 0 Yes 0 No

Was your birth drug induced forceps or suction
 "C" section cord around the neck
 breech prolonged
 natural other: _____

Infant Health: 0 Colicky 0 Repeated infections 0 Childhood illness 0 Hospitalization
Other _____

General Physical Trauma:

Please list any childhood falls/accidents

Type: _____ Age: _____ Hospitalized? Y N
Type: _____ Age: _____ Hospitalized? Y N
Type: _____ Age: _____ Hospitalized? Y N

Please list any accidents or injuries: Auto, work related, sports or other:

Type: _____ Date: _____ Hospitalized? Y N
Type: _____ Date: _____ Hospitalized? Y N
Type: _____ Date: _____ Hospitalized? Y N

Surgeries:

Type: _____ Date: _____ Reason: _____
Type: _____ Date: _____ Reason: _____
Type: _____ Date: _____ Reason: _____

During the day I: Sit Stand Walk Do desk work Phone work Drive
 Do mechanical work Heavy Lifting

Sports and leisure:

I exercise: Daily Weekly Monthly
 Walking Biking Running Swimming Yoga Pilates Weights Aerobic classes
Other: _____

Hours per week watching TV? 0-10 10-20 20-30 30-40
Hours per week on the computer? 0-10 10-20 20-30 30-40

BIOCHEMICAL HISTORY

Please list ALL drugs you currently take or have taken in the past 6 months:

Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N

Please list all nutritional supplements, vitamins or homeopathic remedies you currently take:

Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N

Nutritional Choices

Please grade any dietary selection that is appropriate for you using the following scale:

- FD – I consume this a few times per day
- D – I consume this once per day
- FW – I consume this a few times per week
- W – I consume this once a week
- FM – I consume this a few times per month
- O – I do not consume this
- M – I consume this monthly

- _____ Alcohol
- _____ Diet Foods
- _____ Tobacco
- _____ Dairy (milk products)
- _____ Coffee
- _____ Refined Sugar
- _____ Breads, pastas
- _____ Artificial Sweeteners
- _____ Soft drinks
- _____ Fried Food

The type of diet I usually follow is classified as: _____

PSYCHOLOGICAL / EMOTIONAL HISTORY

General Emotional Trauma:

With each of the following potentially stressful situations, please mark either “P” for past or “C” for current.

	Mild	Moderate	Extreme		Mild	Moderate	Extreme
Childhood stress	_____	_____	_____	Work related stress	_____	_____	_____
School stress	_____	_____	_____	Stress of commuting	_____	_____	_____
Play, or recreational	_____	_____	_____	Loss of a loved one	_____	_____	_____
Family stress	_____	_____	_____	Change in lifestyle	_____	_____	_____
Personal relationships	_____	_____	_____	Change in vocation	_____	_____	_____
Stress of being sick	_____	_____	_____	Abuse	_____	_____	_____

Please check any of the stress coping techniques you currently use:

- Exercise
- Nature
- Deep breathing
- Yoga
- Meditation
- Reading
- Prayer
- Music
- Counselling
- Life Coach
- Bodywork
- Other _____

Commitments

What is your level of commitment to yourself, your life and wellbeing? 0 High 0 Medium 0 Low

Are your present lifestyle choices moving you: 0 Towards health 0 Away from health

How do you grade your physical health?

- Excellent
- Good
- Fair
- Poor
- Getting better
- Getting worse

How do you grade your biochemical health?

- Excellent
- Good
- Fair
- Poor
- Getting better
- Getting worse

How do you grade your psychological / emotional health?

- Excellent
- Good
- Fair
- Poor
- Getting better
- Getting worse

In addition to your main reason for your visit today, what additional health goals do you have for your future? _____

