

APPOINTMENT TIME: \_\_\_\_\_

ph: 717.5433



INITIAL COMPREHENSIVE & CONFIDENTIAL ASSESSMENT

date D \_\_\_\_\_ M \_\_\_\_\_, 200 \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_

Postal Code \_\_\_\_\_ When were you born?: D \_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_\_\_ Sex:  M  F

Home phone:( ) \_\_\_\_\_ - \_\_\_\_\_ Work phone:( ) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_ Cell phone:( ) \_\_\_\_\_ - \_\_\_\_\_

Email address: \_\_\_\_\_ MSP Number: \_\_\_\_\_

Status: Minor  Single  Widowed  Divorced  Separated  Married Spouse's Name: \_\_\_\_\_

Who's your family doctor? \_\_\_\_\_ If you have children, how many? \_\_\_\_\_

What's your current job? \_\_\_\_\_ What's your ideal job? \_\_\_\_\_

Have you ever received chiropractic care?  Yes  No Who referred you? \_\_\_\_\_

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which can damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that have resulted in poor health. Following your exam, the doctor will outline a course of care to begin to correct these layers of damage and recover your health potential.

LOSS OF WHOLE BODY HEALTH (BIRTH TO PRESENT)

From birth, certain stresses in your life start to produce layers of damage to your spine and nervous system. Eventually you may have begun to experience symptoms and bouts of sickness.

Your Birth Process

Was your delivery difficult?  Yes  No If yes:  Forceps  Cesarean  Breech  Other \_\_\_\_\_
Were you breast feed?  Yes  No Did you ever have ear infections?  Yes  No
Were you ever given antibiotics?  Yes  No Did you experience any traumas as a child?  Yes  No
Any childhood illness? \_\_\_\_\_

Your Primary Concern

What is the primary reason for consulting our office today?  Relief Care - Symptom relief of pain or discomfort
(please check only one)  Corrective Care - Correcting, Relieving and Stabilizing the cause
 Prevention - Maximizing the body for the highest degree of health
 I want the doctor to select the type of care appropriate for me

What, if any, is your primary area of complaint today? \_\_\_\_\_

How long has it bothered you? \_\_\_\_\_

Does your pain go to other areas of your body as well? \_\_\_\_\_

How often do you experience this? \_\_\_\_\_

On a scale of 1 to 10 (10 being the worst), what does it feel like when it's at its worst? 1 2 3 4 5 6 7 8 9 10

How would you describe the pain/discomfort?  Dull  Achy  Throbbing  Stabbing  Tight/Stiff  Burning  Sharp  Other

What makes it feel worse? \_\_\_\_\_

What makes it feel better? \_\_\_\_\_

Do you notice any other problems in your body when you get this pain/discomfort? \_\_\_\_\_

Is your condition getting progressively worse?  Yes  No Do you feel your condition can be healed?  Yes  No  Unsure

What have you tried that has helped?  Ice  Heat  Medication  Massage  Physio  Chiropractic  Other \_\_\_\_\_

What have you tried that hasn't helped?  Ice  Heat  Medication  Massage  Physio  Chiropractic  Other \_\_\_\_\_

Please list ALL drugs (prescribed or non-prescribed) that you are or have been using and what you're taking them for: \_\_\_\_\_

Have you ever had to be hospitalized or had surgery? If yes, why and when? \_\_\_\_\_

Have you ever been in an accident (even if it was minor)? If yes, what kind and when? \_\_\_\_\_

Have you had any non-auto accidents or falls? \_\_\_\_\_

## A Few YES or NOs

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- Do you smoke? Yes No I used to Sometimes I wish I didn't
- Do you drink alcohol? Yes No If yes, how often? \_\_\_\_\_
- Have you had headaches? Yes No If yes, how often? \_\_\_\_\_
- Have you had dizziness? Yes No If yes, how often? \_\_\_\_\_
- Have you had loss of concentration? Yes No If yes, how often? \_\_\_\_\_
- Have you had blurred vision? Yes No If yes, how often? \_\_\_\_\_
- Have you had depression? Yes No If yes, how often? \_\_\_\_\_
- Have you had difficulty sleeping? Yes No If yes, how often? \_\_\_\_\_
- Have you had a low level of energy? Yes No If yes, how often? \_\_\_\_\_
- Have you had ear problems? Yes No If yes, how often? \_\_\_\_\_
- Have you had balance problems? Yes No If yes, how often? \_\_\_\_\_
- Have you had fainting spells? Yes No If yes, how often? \_\_\_\_\_
- Have you had heart palpitations? Yes No If yes, how often? \_\_\_\_\_
- Have you had teeth problems? Yes No If yes, explain: \_\_\_\_\_
- Have you had eye problems? Yes No If yes, explain: \_\_\_\_\_
- Have you had sport/recreation injuries? Yes No If yes, explain: \_\_\_\_\_
- Do you have stress at work? Yes No If yes, explain: \_\_\_\_\_
- Do you have emotional stress? Yes No If yes, explain: \_\_\_\_\_
- What kind of regular exercise do you do? \_\_\_\_\_ I don't exercise regularly
- Are you satisfied with your current body weight? Yes No If no, do you want help to change that? Yes No

## Previous Chiropractic Care

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- If you've had previous chiropractic care, who was your doctor? \_\_\_\_\_ Where? \_\_\_\_\_
- When? \_\_\_\_\_ Were X-rays taken? Yes No Have you had X-rays in the last 6 months: Yes No
- What was the primary reason for consulting that office?  **Relief Care** - Symptom relief of pain or discomfort
- Corrective Care** - Correcting, Relieving and Stabilizing the cause
- Prevention** - Maximizing the body for the highest degree of health
- Did it work? Yes No Please explain: \_\_\_\_\_
- Are you wearing: Heel Lifts Sole Lifts Inner Soles Arch Supports

Is the any possibility that you may be pregnant? Yes No

## Are you currently experiencing any problems in the following areas? (please check Yes or No)

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- |                               |  |                     |  |
|-------------------------------|--|---------------------|--|
| Allergies                     | <input type="radio"/> Yes <input type="radio"/> No | Foot pain           | <input type="radio"/> Yes <input type="radio"/> No |
| Sinuses                       | <input type="radio"/> Yes <input type="radio"/> No | Colon               | <input type="radio"/> Yes <input type="radio"/> No |
| Pain or Stiff Neck            | <input type="radio"/> Yes <input type="radio"/> No | Chest Pain          | <input type="radio"/> Yes <input type="radio"/> No |
| Pain or Stiff Upper Back      | <input type="radio"/> Yes <input type="radio"/> No | Lung Pain           | <input type="radio"/> Yes <input type="radio"/> No |
| Pain or Stiff Lower Back      | <input type="radio"/> Yes <input type="radio"/> No | Asthma              | <input type="radio"/> Yes <input type="radio"/> No |
| Pain or Stiff Hips            | <input type="radio"/> Yes <input type="radio"/> No | Kidney              | <input type="radio"/> Yes <input type="radio"/> No |
| Numbness anywhere in the body | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure | <input type="radio"/> Yes <input type="radio"/> No |
| Tingling anywhere in the body | <input type="radio"/> Yes <input type="radio"/> No | Stomach             | <input type="radio"/> Yes <input type="radio"/> No |
| Right Shoulder                | <input type="radio"/> Yes <input type="radio"/> No | Bladder             | <input type="radio"/> Yes <input type="radio"/> No |
| Left Shoulder                 | <input type="radio"/> Yes <input type="radio"/> No | Liver               | <input type="radio"/> Yes <input type="radio"/> No |
| Leg pain or cramps            | <input type="radio"/> Yes <input type="radio"/> No | Other _____         |  |

## Goals for Care

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- Health is more than just physical function. Health certainly *includes* physical health, but also incorporates emotional health, mental health, social health, and spiritual health. What things/areas in your health would you most like to see improve over the next 12 months (*please be specific*) \_\_\_\_\_
- What would you say is the best part of your health and overall well-being? \_\_\_\_\_
- Have you *fully* filled out this form to the best of your ability? Yes No If no, please review and complete each section fully then sign.

\_\_\_\_\_  
signature

\_\_\_\_\_  
date

***Thank you for taking the time to complete this form. It will become part of your file and will help the doctor determine what type of care is best recommended for you.***