☐ **Dr. Kim Patton** BSc. D.C.

73 Ontario Street, Port Hope
T: 905 885-6938 F: 905 885-8430
www.betterbacks.ca

Name:_____ Date:_____

Address:_____
Residence and Mailing City Province Postal Code

Home Telephone Number: ( ) _____ Work Telephone Number: ( ) _____

Cell Number: ( ) _____ Email: _____

Birthdate: (dd/mm/yy)_____ Age:_____ Male:____ Female:_____

Occupation:_____ Employer's Name: _____

Single:____ Married: ___ Divorced: _____ Widowed: ___ Spouse's Name: _____

Number of children: _____ Names of Children: _____

Emergency Contact:_____ Phone Number:_____ Relationship:_____

Who may we thank for referring you to our office?_____

How did you hear about our office? Circle all that apply: Radio Ad/Newspaper Ad/Internet/Word-of-mouth/Lecture

Other: _____

Your Health Profile

Why This Form Is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to health potential.

The Beginning Years (To Age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	YES	NO	UNSURE
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take/use any drugs?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree)	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	YES	NO	UNSURE
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas? (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

Comments: _____

_____

_____

_____

_____

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Adult Years (Age 18 to present)

	YES	NO
Do/did you smoke?	☐	☐
Do/did you drink alcohol?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐

	YES	NO
Do/did you play any adult sports?	☐	☐
Do/did you participate in extreme sports?	☐	☐

On a scale of 1-10 describe your stress level:
(1 = none, 10 = extreme)
Occupational:_____ Personal: _____

On a scale of POOR, GOOD, or EXCELLENT, describe your:
Diet: _____ Exercise: _____ Sleep: _____ General Health: _____

If you have no symptoms or complaints, and are here for wellness services, please check (√) here _____ and skip to "**Family Health History**". Those who have symptoms or complaints need to complete the following section.

Current Health Condition

Current Complaint(s): _____
Other doctors seen for this condition? ☐ Yes ☐ No Who? _____
Type of Treatment: _____ Results: _____
When did this condition begin? _____ Has the condition occurred before? ☐ Yes ☐ No
Is the condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other: _____
Date of Accident: _____ Time of Accident: _____
What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Lying Down
☐ Walking ☐ Cold ☐ Dampness ☐ Other: _____
What relieves your condition? ☐ Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: _____
Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better
Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning
☐ Constant ☐ Intermittent Other: _____
Please describe how it feels when this problem is at its worse: _____
_____
Place an X on the grade to indicate the severity of your pain:

LEAST 1 2 3 4 5 6 7 8 9 10 *WORST*

How does this problem interfere with:
Your ability to work? _____
Your ability to enjoy your family or your social time? _____
Your ability to enjoy your hobbies or sports? _____
Drugs you take now: ☐ Nerve Pills ☐ Painkillers/Muscle Relaxers ☐ Blood Pressure Medicine
☐ Insulin ☐ Other: _____
Do you suffer from any other condition than the one you are now consulting us for? _____
_____
On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: _____
Have you had spinal X-rays taken? ☐ Yes ☐ No If yes, when and where? _____

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Family Health History

Name of Family Physician: _____

Please indicate any health issues that are present in your family: *eg: cancer, diabetes, heart disease*

Parents: _____

Siblings: _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.
Check any of the following you have had in the past six months:

Nervous System
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Stress

Musculo-Skeletal
- ☐ Low Back Pain
- ☐ Gas/Bloating After Meals
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Black/Bloody Stool
- ☐ Arm Pain
- ☐ Colitis
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

General
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Gastro-Intestinal
- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

Genito-Urinary
- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine

Male / Female
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

Females Only

When was your last period?

_____

_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

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Check any of the following diseases you have had:

☐ Pneumonia	☐ Chicken Pox	☐ Mental Disorder
☐ Mumps	☐ Arthritis	☐ Anemia
☐ Influenza	☐ Tuberculosis	☐ Heart Disease
☐ Rheumatic Fever	☐ Diabetes	☐ Lumbago
☐ Small Pox	☐ Epilepsy	☐ Measles
☐ Pleurisy	☐ Whooping Cough	☐ Thyroid
☐ Polio	☐ Cancer	☐ Eczema

List any medications you are taking: _____
_____
_____
_____

Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Preventative Care). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ Preventative Care – Life Enhancement and Wellness Care
☐ Corrective Care – Removing Cause and Remodeling Soft Tissue
☐ Relief Care – Band-Aid Care Only
☐ Check here if you want the doctor to select the type of care appropriate for your condition.

Custom Orthotics

Your feet have a direct impact on the rest of your body. Like the foundation of your house, your feet support the weight of everything above them. When a small problem develops in your feet, a subtle change in the way you walk will cause a chain reaction of adjustments in your posture and walking mechanics. These changes can put stress on joints in your body. Custom fit orthotics help restore the normal balance and alignment of your body by gently correcting foot abnormalities.

Do you currently wear orthotics? ☐ Yes ☐ No Have you ever worn orthotics? ☐ Yes ☐ No

If Yes, how long ago where you fitted for them? _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

_____ _____
Signature Date