Heart Mind Body
HEALTH & WELLNESS

Dr. Dodie Elkins, B.Sc., D.C.
CHIROPRACTOR

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Confidential Patient Information

Name ______________________________ Date ____________________

Phone: Res ______________ Bus __________________ Cell ______________

Email ____

Address ____________________ City ______________ Postal Code ________

Date of Birth (M/D/Y) ______________ Single ☐ Married ☐ Common Law ☐ Div ☐ Sep ☐ Widow/er ☐

Nº of Children _____ Family Physician ______________________________

Occupation ______________ Nº of Years __________ Employer ________________

Health Card Nº ____________________________ Version Code ________________

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

Your Health Profile

As a solution based Chiropractor. My goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity to improve you health potential and wellness. On a daily basis we experience physical, chemical and emotional stress that can accumulate and result in serious loss of health potential. Most time 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 your health potential.

Childhood & Adolescence Stresses

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.

Y ☐ / N ☐ Did you have any childhood illnesses?
Y ☐ / N ☐ Did you play youth sports?
Y ☐ / N ☐ Did you take/use recreational drugs?
Y ☐ / N ☐ Were you vaccinated?
Y ☐ / N ☐ Were you involved in any car accidents?
Y ☐ / N ☐ Were you under regular chiropractic care?
Y ☐ / N ☐ Did you have any serious falls as a child?
Y ☐ / N ☐ Have you fallen/jumped from a heights over 3 feet?
Y ☐ / N ☐ Was there prolonged use of antibiotics or inhaler?
Y ☐ / N ☐ Were teeth extracted or dental orthodontics used?
Y ☐ / N ☐ Did you suffer any physical or emotional traumas?

Family History

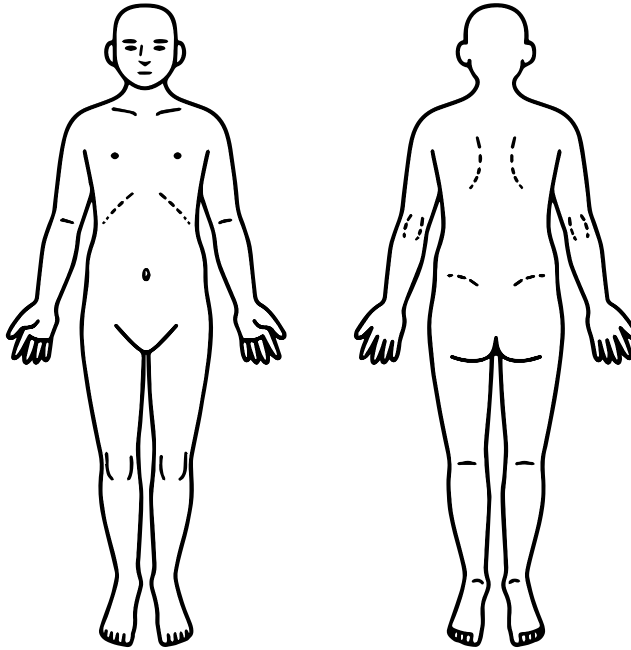
Our office attracts and cares for families. We are interested in how their health background may affect you, and your specific concerns. Please note any health concerns you have knowledge of.

Name	Relationship	Past & Present Health Problems
1.		
2.		
3.		
4.		

Your Current Concerns

If you have no complaints or symptoms, and are here for your wellness assessment, please check ____ and proceed to the next page.

Please describe the locations of your chief complaint using the key. Chiropractic assess the whole body so please indicate all areas of concern, even if you think they are unrelated to your chief concern. (Eg: Jaw discomfort, digestive discomfort, ear/balance trouble, wrist discomfort)



Key

Please describe in detail your symptoms. Place letter of the key with your areas of concern.

- **A** - ache
- **B** - burning
- **N** - numbness
- **P** - pins/needles
- **S** - stabbing

Reason for your visit? ______________________________

When did this condition(s) begin?______________________________

Has it occurred before? ______________________________

How frequent is the complaint? Constant ☐ Daily ☐ Intermittent ☐ Nights Only ☐ Other ☐

Since it began, it is? About the same ☐ Getting better ☐ Getting worse ☐

What makes it worse? ______________________________

How long does it last? All day ☐ A few hours ☐ Minutes ☐ Is it? Mild ☐ Moderate ☐ Severe ☐

Please rate your pain on the scale: No Pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Severe pain ☐

Y ☐ / N ☐ Is the pain local? Y ☐ / N ☐ Does it go down your leg / arm?

What relieves the problem for you? (eg: rest, ice, heat, stretching, medication) ______________________________

How has this impacted your life?______________________________

____

____

What have you had to give up because of this? ______________________________

____

Traumas: Physical Injury History

Y ☐ / N ☐ Have you ever had any significant falls, surgeries or other injuries as an adult? If yes, please explain. ______________________

____

Y ☐ / N ☐ Any auto accidents? If yes, please explain. ____

Y ☐ / N ☐ Do you exercise? Frequency? ________________Type of exercise? ____

Y ☐ / N ☐ Have you ever been unconscious?

Y ☐ / N ☐ Do you commute to work? If yes, how many minutes per day? ____

How do you normally sleep? Back ☐ Side ☐ Stomach ☐ Do you wake up? Refreshed & ready ☐ Stiff & tired ☐

How many hours per day do you typically spend sitting at a desk or using a computer, tablet or phone? ___________________________

List any problems with flexibility (ex: putting on shoes, socks, etc.): ____

____

Toxins: Chemical & Environmental Exposure

Please rate your CONSUMPTION per week for each:

		Low		Moderate		High
Alcohol	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Water	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Sugar	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Dairy	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Gluten	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

		Low		Moderate		High
Processed Foods	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Artificial Sweeteners	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Sugary Drinks	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Cigarettes	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Recreational Drugs	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Please list any drugs/medication/supplements you take and why.

Medications: Pain ☐ Blood Thinners ☐ Blood Pressure ☐ Heart ☐ Anxiety ☐ Other ☐

____

Supplements: ____

Thoughts: Emotional Stresses & Challenges

Please rate your STRESS for each:

		Low		Moderate		High
Home	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Work	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Live	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

		Low		Moderate		High
Money	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Health	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐
Family	None ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Your Current Health Goals

Please list your current health goals.

1. ____
2. ____
3. ____

Back Problem or Health Problem?

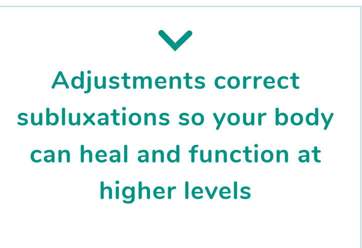
Subluxations (nerve interference or damage) cause body & mind miscommunication, malfunction and dis-ease

Spinal Level	Body Pain	Internal Organ or Body Malfunction	Common Internal Symptoms Potentially Indicate Malfunction or Dis-Ease
Cranial C1, C2	Headache	All anatomical structures within the head; Brain, Cranial Nerves, Eyes, Ears, Nose, Throat, Sinuses etc.	Spacey, dizzy, low energy, memory trouble, brain fog, ADD, ADHD, ear aches, tinnitus, nose bleeds, sinus problems, snoring, sleep disorders, sore throats, colds, flus, itchy and achy eyes, allergies, food sensitivity
C3	Neck	Diaphragm	Difficult to take a deep breath, chronic fatigue, anxiety, vertigo, shortness of breath, allergies
C4	Neck	Thyroid	Low = weight gain, feelings of being cold High = insomnia, nervousness, swollen glands
C5	Shoulder	Sugar Handling Function	Craving sweets, tired after eating, headache if too long between meals, emotional, heart palpitations
C6	Arm	Stomach	Stomach pains after eating, needs antacids
C7	Hand	Liver	Sluggishness, sneezing, nightmares, burning feet, allergies
T1, T2	Finger	Heart	Coronary artery disease, functional heart conditions, high or low blood pressure, chest pain
T3		Lungs & Bronchi	Asthma, shortness of breath, chronic coughs, allergies
T4	Upper Back	Gall Bladder	Heartburn, bloating after meals, gassy, burping, trouble with fatty foods
T5		Stomach	Heartburn, indigestion, stomach troubles, ulcers
T6		Pancreas	Craving sweets, tired after eating, headaches if too long between meals, emotional, heart palpitations, indigestion
	Mid Back	Spleen & Immune Function	Lowered resistance, immune deficiencies, frequent colds or flus, allergies
T8		Liver	Headaches, low energy, sneezing, nightmares, burning feet
T9		Adrenal Glands	Overwhelmed by stress, allergies
T10		Small Intestine	Digestive complaints: 1-2 hours after eating
T11, T12		Kidneys & Bladder	Decreased urine output, swollen ankles, puffy eyelids, kidney or bladder infections, high or low blood pressure
	Low Back	Ileocecal Valve	Sciatica, bad breath, flatulence, headaches when sleeping too long, dark circles under eyes, toxicity, allergies
	Hip	Cecum	Sciatica, digestive complaints 1-2 hours after eating, abdominal cramps, allergies
	Leg	Endocrine Glands: Thyroid, Pancreas, Liver, Adrenals	See organs' primary subluxation sites: C4, C5, C7, T6, T8
	Knee, Ankle	Colon, Prostate or Uterus	Sciatica, bowel problems, coated tongue, headaches, allergies, hemorrhoids, varicose veins, prostate problems, impotence, painful periods, PMS, menopause symptoms
Sacrum	Foot	Reproductive Organs	Sciatica, reproductive disorders
Coccyx	Toe	Overall tone of the nervous system	Sciatica, chronic depression, migraines, vertigo, dyslexia, epilepsy, ADD, ADHD, compulsive disorders, sensitivity to light, PMS, painful periods, menopause symptoms, impotence

Cranial, C1, C2, C3, C4, C5, C6, C7, T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, T12, L1, L2, L3, L4, L5, Sacrum, Coccyx

Chiropractic Premise

1. Your nervous system (brain, spinal cord and nerves) controls and coordinates **everything** in your body and mind.
2. When your nerve energy flows abundantly without obstruction, your body and mind at 100% self-communicating, self-healing, and self-regulating and robust.
3. When subluxations (nerve interference or damage) impede nerve flow, similar to static on your cell phone, you are no longer functioning at 100% and you health vitality are compromised.
4. Subluxations are caused by our inability to handle life's three major stressors; physical, mental-emotional and chemical.
5. Left uncorrected, subluxations have devastating effects upon human health and well-being, leading to breakdown, malfunction and dis-ease.
6. Our goal is to locate subluxations, remove them and their causes and allow you to heal yourself on every level.
7. Only chiropractors can determine if you have subluxations. WHO DO YOU KNOW THAT NEEDS TO BE CHECKED?



Patient Name ____________________ Date ____________________

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REFERENCES: Fix, J.D., Ph.D., *Neuroanatomy, 3rd Edition*, Lippincott Williams & Wilkins, 2002; Kandel, E.R., Schwartz, J.H., Jesseli, T.M., *Principles of Neural Science*, Appleton & Lange, 1991; Hoppenfield, S. M.D., *Physical Examination of the Spine and Extremities*, Appleton-Century-Crofts, 1976; Netter, F.H. M.D., *The CIBA Collection of Medical Illustrations, Vol 1, Nervous System, Part 1, Anatomy and Physiology*, Ciba Pharmaceuticals Division, Ciba-Geigy Corp, 1991. *This chart has been simplified for demonstration purposes. It does not illustrate all intricate nerve pathways. The symptoms listed are a guide to potential effects of subluxations.*Special thanks and recognition to Dr. Gurutrang Singh Khalsa in the creation of this chart. ©TheOHCSystem, Inc. (808) 878-8384 - TheOHCSystem.com