



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

N° of Children _____ Family Physician _____

Occupation _____ N° of Years _____ Employer _____

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

Family History

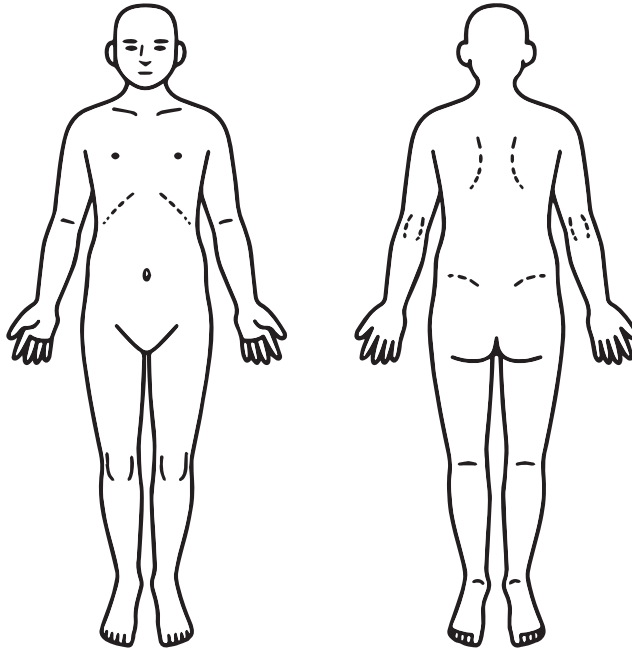
Our office attracts and cares for families. We are interested in how their health background may affect you, and your specific concerns. Please note any health concerns you have knowledge of.

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 P - pins/needles
 B - burning S - stabbing
 N - numbness

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			Low	Moderate	High				
Alcohol	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	Processed Foods	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Water	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	Artificial Sweeteners	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Sugar	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	Sugary Drinks	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Dairy	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	Cigarettes	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Gluten	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	Recreational Drugs	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

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			Low	Moderate	High				
Home	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	Money	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Work	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	Health	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Live	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	Family	None <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

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
	T8	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
	L4	Low Back	Ileocecal Valve	Sciatica, bad breath, flatulence, headaches when sleeping too long, dark circles under eyes, toxicity, allergies
	L5	Hip	Cecum	Sciatica, digestive complaints 1-2 hours after eating, abdominal cramps, allergies
	Sacrum	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	

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 your 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?


Adjustments correct subluxations so your body can heal and function at higher levels

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., Jessell, T.M., *Principles of Neural Science*, Appleton & Lange, 1991; Hoppenfield, S. M.D., *Physical Examination of the Spine and Extremities*, Appleton-Century-Crofts, 1976; Neller, 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. Gurunrang Singh Khalsa in the creation of this chart. ©TheOHCSystem, Inc. (808) 878-8384 - TheOHCSystem.com