



# Your Wellness History – Health Profile

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Prov: \_\_\_\_\_ PC: \_\_\_\_\_  
 Telephone: Home \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
 Email address: \_\_\_\_\_ Status:  Single  Married  Divorced  Widowed  
 Occupation: \_\_\_\_\_ Name of Employer: \_\_\_\_\_  
 # of Children: \_\_\_\_\_ Names/Ages: \_\_\_\_\_  
 Have you seen a Chiropractor before?  Yes  No M.D. \_\_\_\_\_  
 Who did you see? \_\_\_\_\_ What techniques were used? \_\_\_\_\_  
 Have you ever seen a wellness chiropractor?  Yes  No How did you hear about our office? \_\_\_\_\_

## Your Health Profile

### Why This Form is Important?

As a Creating Wellness Centre, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your health potential.

**General History:** Please reflect on all the stages in your life and circle as many as apply; **C** for Childhood, **T** for Teenager, **A** for Adult and **N** for Not applicable. If you circle a category other than “N”, please take a moment on to provide a brief explanation of your experience.

### I. EMOTIONAL STRESSES:

**Explain:**

Relationships	C	T	A	N
Career	C	T	A	N
Children	C	T	A	N
Money	C	T	A	N
Fast-Paced Life	C	T	A	N
Held in Feelings	C	T	A	N
Quick Temper	C	T	A	N
Verbal Abuse	C	T	A	N
Perfectionism	C	T	A	N
Procrastination	C	T	A	N
The Sickness or Loss of Loved One	C	T	A	N

### II. CHEMICAL STRESS:

Environmental (Pollution)	C	T	A	N
Smoking or Exposure to Secondhand Smoke – Amount?	C	T	A	N
Poor Diet	C	T	A	N
Caffeine – Amount?	C	T	A	N
Excessive Sugar	C	T	A	N
Alcohol consumption	C	T	A	N
Artificial Sweeteners	C	T	A	N
Prescription Drugs	C	T	A	N
Over-the-Counter Drugs (e.g., Tylenol, Advil, Motrin)	C	T	A	N

Allergies	C	T	A	N
Work with fumes, chemicals, dust	C	T	A	N

**III. PHYSICAL STRESS**

Birth Traumas (as mother or child)	C	T	A	N
Slips/Falls	C	T	A	N
Car Accidents	C	T	A	N
Sports Injuries	C	T	A	N
Broken Bones	C	T	A	N
Hospitalizations	C	T	A	N
Physical Abuse	C	T	A	N
Work Injuries	C	T	A	N
Poor Posture	C	T	A	N
Sitting on Your Wallet	C	T	A	N
Sleeping Position/Stomach	C	T	A	N
Extensive Computer Work	C	T	A	N
Carrying Heavy Purse/Backpack/Child	C	T	A	N
Repetitive Lifting/Bending	C	T	A	N
Driving for Many Hours	C	T	A	N
Continuous Sitting/Standing	C	T	A	N

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

<input type="checkbox"/> Headaches	<input type="checkbox"/> Menstrual pain	<input type="checkbox"/> Depression	<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Pins and needles in arms	<input type="checkbox"/> Menstrual irregularity	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Sinus infection
<input type="checkbox"/> Pins and needles in legs	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Enlarged glands
<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> Nervousness / Anxiety	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Irritability	<input type="checkbox"/> Speech problem	<input type="checkbox"/> Cardiovascular problems
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Cold sweats	<input type="checkbox"/> Head injuries	<input type="checkbox"/> Poor circulation
<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Fever	<input type="checkbox"/> Back pain	<input type="checkbox"/> Cold hands / feet
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fainting	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Respiratory problems
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Urinary problems	<input type="checkbox"/> Stiff neck	<input type="checkbox"/> Chronic cough
<input type="checkbox"/> Tension	<input type="checkbox"/> Eyes bothered by light	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Ear / Eye pain	<input type="checkbox"/> Blurred / Double vision	<input type="checkbox"/> Swollen joints	<input type="checkbox"/> Stroke
<input type="checkbox"/> Deafness	<input type="checkbox"/> Stomach upset	<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Kidney infection
<input type="checkbox"/> Buzzing / Ringing in ears	<input type="checkbox"/> Heart burn	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Tenderness in breasts
<input type="checkbox"/> Constipation / Diarrhea	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Asthma	<input type="checkbox"/> Prostate problems

**Family Health Profile**

Is there a family history of:

Mother:  Arthritis  Heart Disease  Cancer  Diabetes  Other: \_\_\_\_\_

Father:  Arthritis  Heart Disease  Cancer  Diabetes  Other: \_\_\_\_\_

Please check all that are relevant.

<b>Do you:</b>	<b>Would you like to know more about:</b>
<input type="checkbox"/> Drink ½ your body weight in ounces of water?	<input type="checkbox"/> Proper nutrition and meal planning.
<input type="checkbox"/> Exercise regularly?	<input type="checkbox"/> Proper exercise routines and techniques.
<input type="checkbox"/> Take vitamins or supplements?	<input type="checkbox"/> How to deal with lifestyle stress.
<input type="checkbox"/> Practice positive thinking, regular relaxation or meditation	



Are you concerned about your condition worsening?  Yes  No

We don't want this, but how would it affect your life if it did get worse? \_\_\_\_\_

What is your greatest concern; what do you hope the doctor can do for you and how long do you think it will take? \_\_\_\_\_

If you got better, how would that affect your life, i.e. are there things you would like to do if you got well? \_\_\_\_\_

If the doctor feels that this is something he/she feels he/she can help you with, is this something you would like to get taken care of at this time?  Yes  No

### Your Goals

➤ On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/psychological/lifestyle stress levels:

Scale = \_\_\_\_\_ Occupational stress: \_\_\_\_\_

Scale = \_\_\_\_\_ Personal stress: \_\_\_\_\_

➤ On a scale of 1 to 10 (1 = poor, 10 = excellent), describe your habits and condition as it relates to:

Eating \_\_\_\_\_ Exercise \_\_\_\_\_ Sleep \_\_\_\_\_ Energy Levels \_\_\_\_\_ General Health \_\_\_\_\_ Wellness lifestyle \_\_\_\_\_

**To successfully succeed in your healing journey, it is important to have a plan to begin to counter balance the stresses in your life.**

**Please list 3 goals for each category that will help facilitate your wellness plan.**

<b>Wellness Goals</b>		
<b>Be Fit. (Physical)</b>	<b>Eat Right. (Bio Chemical)</b>	<b>Think Well. (Psychological)</b>
1	1	1
2	2	2
3	3	3

Is there anything else you wanted me to tell the doctor?  
\_\_\_\_\_  
\_\_\_\_\_

I consent to a professional and complete chiropractic examination, and to any diagnostic scans and radiographic examination that the doctor deems necessary. I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Rate your health and wellness.**  
 Place an 'X' that denotes where you believe is your current level of wellness.  
 Place an 'O' indicating where you would like your wellness to be.

0 - 50 Very Challenged	50 - 75 Challenged	75 - 100 Transition	100 - 125 Good	125 + Excellent
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What brings you into our office today? \_\_\_\_\_

### Chief Complaint

Location:

Onset:

Duration:

Radiation:

Frequency:

Intensity:

Character:

Aggravating factors:

Relieving factors:

Associated Symptoms:

Does this interfere with your:  Leisure  Work  Sleep  Sports  Other

Have you seen other doctors for this condition?  Chiropractor  MD  Other

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Were you pleased with the results?  Yes  No

