PERFORMANCE posture

Vital Information

The human body is designed to be healthy. Throughout life, events occur which interfere with your health expression. This personal history will uncover the layers of stress and tension, especially to your nerve system, that resulted in poor health. Following your assessment, the doctor will outline a course of care to correct these layers of stress and tension and recover your innate potential.

Name: ______________________________ Date: _____M/_____D/________Y

Address: ______________________ City/Prov. ____________ Postal Code: ________

Home #:________________ Work #: ________________ Cellular #: ________________

E-mail: ________________________ Occupation: ________________________

Age: ______ Birthday: _____M/_____D/________Y Gender: M F Marital Status: M S W D C.Law

Spouse's Name: ______________________ Spouse's Occupation: ____________________

Children's Name(s): ______________________________ And their ages: ____________

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

CHILDHOOD (0 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. Certain stresses in your life start to produce layers of damage to your spine and nervous system. Please answer the following questions to the best of your ability.

Was your delivery difficult? Y N Unsure
Forceps / Cesarean / Breech / Other:_____________

Did you have any childhood illnesses? Y N Unsure
List: ______________________________

Did you have any surgery? Y N Unsure
List: ______________________________

Did you have any serious falls as a child? Y N Unsure

Did you play youth sports? Y N
List: ______________________________

Were you involved in any car accidents as a child? Year: ____________________ Y N Unsure

Did you suffer any other traumas (physical or emotional)? Y N Unsure
List: ______________________________

Was there prolonged used of drugs? (antibiotics, inhalers, etc) Y N Unsure
List: ______________________________

Were you vaccinated? Y N Unsure

As a child, did you receive regular chiropractic care? Y N Unsure

ADULTHOOD (age 18 to present)

Do/did you take medications? Y N

What & when? ______________________________

On a scale of 1 – 10 describe your stress level:
(1 = none / 10 = extreme)

Occupational __________ Personal __________

Have you had previous chiropractic care? Y N

With whom? ________________ When? ______

Reason? ______________________________

Were scans performed? Y N When?__________

Were x-rays taken? Y N When?__________

Do/did you smoke? Y N
When? ______________

Do/did you drink alcohol? Y N
When? ______________

Have you been in any car accidents Y N

When? ______________________________

Have you had any surgeries? Y N

What & when? ______________________________

What do you do for exercise? How often? __________

____

Do/did you wear: ▫Heel Lifts ▫Sole Lifts

When? ________ ▫Inner Soles ▫ Arch Supports

Women Only

Do you take birth control? Y N Are you pregnant? Y N Maybe Date of last period ____________

SYMPTOMS AND HEALTH CONCERNS (PRESENT STATE OF HEALTH)

If you have no symptoms or concerns, and are here for wellness services, please check (√)_____here and skip to "Family Health Profile." Otherwise, please continue and describe your main areas of concern.

What is your major concern presently: ______________________________

How long have you had this concern? __________ Have you experienced something similar in the past? ________

What activities aggravate your concern? ______________________________

What relieves your concern? ______________________________

Are you getting pain or numbness in your: ▫ Arms ▫ Hands ▫ Head ▫ Buttock ▫ Legs ▫ Calf ▫ Feet

Is your concern getting progressively worse? ▫ Yes ▫ No ▫ It's constant ▫ It comes and goes

If you are experiencing pain or discomfort, they are: ▫ Sharp ▫ Dull ▫ Burning ▫ Tight ▫ Throbbing

Is this interfering with your: ▫ Work ▫ Daily Routine ▫ Other ______________________________

Have you seen anyone else for this concern? ______________________________

If you could pick one outcome from today's visit, and there were no restrictions, what would it be?

____

Please check (√) all symptoms you have had in the last 6 months, even if they do not seem related to your current concern.

▫ Headaches	▫ Pins and needles in legs	▫ Fainting	▫ Neck Pain
▫ Pins and needles in arms	▫ Loss of smell	▫ Back pain	▫ Loss of balance
▫ Dizziness	▫ Buzzing in ears	▫ Ringing in ears	▫ Nervousness
▫ Numbness in fingers	▫ Numbness in toes	▫ Loss of taste	▫ Stomach upset
▫ Fatigue	▫ Depression	▫ Irritability	▫ Tension
▫ Sleeping problems	▫ Neck stiffness	▫ Cold hands	▫ Cold feet
▫ Diarrhea	▫ Constipation	▫ Fever	▫ Hot flashes
▫ Cold Sweats	▫ Lights bother eyes	▫ Problem urinating	▫ Heartburn

On a scale from 1-10 (1=not important/10=utmost importance)**my commitment to my health and well-being is: ______**

FAMILY HEALTH PROFILE

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health concerns you may have about your:

Children: ______________________________

Spouse: ______________________________

Mother: ______________________________

Father: ______________________________

Brothers: ______________________________

Sisters: ______________________________

Others: ______________________________

Signature: ______________________________