Personal Information

Name_____ Date_____

Address_____City _____

Postal Code_____ Date of Birth: M___ D ___ Y _____ Age _____

Home Phone _____Cell Phone _____ E-mail _____

Where do you prefer to be contacted? Home ____ Work ____ Cell ____

Business/Employer_____ Business Ph. _____ Ext._____

Type of work_____

Marital Status: Single/Married /Partner /Divorced /Widowed Spouse's Name _____

Do you have children? Y N Names/Ages of Children: _____

Are you pregnant? Y N Weeks _____

Whom may we thank for referring you to Valley Chiropractic?_____

Check the phrase(s) that most represent your approach to your health & lifestyle:

I make choices based on: __Crisis/symptoms __Preventing problems

__ Improving health, lifestyle & quality of life __ Doing whatever it takes to be at my best

Health Concerns *(If there are no current concerns and this assessment is to ensure optimum health and functioning, skip to next page)*

Concern	Severity 1=mild 10=worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of time is the symptom present?

Is this condition interfering with your:

0 Work 0 Family 0 Sleep 0 Daily Routine 0 Sports/Activities 0 Quality of Life

Other: _____

What other health practitioners you have seen? (Mark P for past or C for current)

__ Chiropractor __ Medical doctor __ Naturopath __ Physiotherapist

__ Massage therapist Other _____

Where are you now?

1----------50----------100
(Death) *(Symptoms)* *(Optimal Health)*

Where would you like to be? (1 – 100) ___ How long do you think it would take to get there? _____

Please circle: Do you feel your daily choices are moving you away from or towards health & wellbeing?

What is your level of commitment to yourself, your life and wellbeing? 0=Low 10=High _____

I would rate the overall movement and flexibility in my neck 10 = flexible, 0 = rigid	
I would rate the overall movement and flexibility in my mid back 10 = flexible, 0 = rigid	
I would rate the overall movement and flexibility in my low back 10 = flexible, 0 = rigid	
I am able to notice tension and release it in my body. 10 is I can completely notice tension and release it, 0 is not at all	
My overall posture & ease in standing straight 10 = great, 0 = terrible	
I sleep deep and wake up feeling rested 10 = rested, 0 = tired	
I feel I have energy for all my daily activities 10 = a lot, 0 = none	
I have effective strategies to deal with emotional stress 10=excellent, 0=none	
My stress levels are: 10=extremely high, 0=virtually none	
My diet is 10= excellent, 0 = terrible	
My exercise is 10 = excellent, 0 = none	
My immune system is strong. (I am rarely ill, and recover quickly).10 = yes 0 =no	
My balance and co-ordination is good. 10=yes 0=no	
I have good focus, concentration and memory & creativity. 10=yes, 0=no	
My breathing is good (I am rarely short of breath or have asthma) 10=yes, 0=no	
My digestive system is working well. (I rarely feel gassy or bloated, or have heart burn, and have regular daily bowel movements.) 10=yes, 0=no	
My reproductive/hormonal health is good. (I have minimal symptoms like PMS, menopausal issues, and have a healthy sex drive) 10=yes, 0=no N/A	
I feel emotions like anger, depression, unhappiness, hopelessness, or feeling "stuck" 10 = daily , 0 = rarely	
I feel emotions like joy, happiness, gratitude, hope 10 = daily, 0 = rarely	
I have balance in my life and a high level of life enjoyment. 10=yes, 0=no	

Values

What are the three things you spend your time doing the most?

1:_____
2:_____
3:_____

What do you spend most of your money on, not include living expenses?

1:_____
2:_____
3:_____

General Physical Trauma:

Please list any childhood falls/accidents

Type:_____ Age: _____ Hospitalized? Y N
Type:_____ Age: _____ Hospitalized? Y N
Type:_____ Age: _____ Hospitalized? Y N

Please list any accidents or injuries: Auto, work related, sports or other:

Type:_____ Date: _____ Hospitalized? Y N
Type:_____ Date: _____ Hospitalized? Y N
Type:_____ Date: _____ Hospitalized? Y N

Surgeries:

Type:_____ Date: _____ Reason: _____
Type:_____ Date: _____ Reason: _____
Type:_____ Date: _____ Reason: _____

During the day I: □ Sit □ Stand □ Walk □ Do desk work □ Phone work □ Drive
□ Do mechanical work □ Heavy Lifting

Sports and leisure:

I exercise: □ Daily □ Weekly □ Monthly
□Walking □Biking □Running □Swimming □Yoga □Strength training □Aerobic classes
Other: _____

Hours per week watching TV? 0-10 10-20 20-30 30-40
Hours per week on the computer? 0-10 10-20 20-30 30-40

BIOCHEMICAL HISTORY

Please list ALL drugs you currently take or have taken in the past 6 months:

Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N

Please list all nutritional supplements, vitamins or homeopathic remedies you currently take:

Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N

Nutritional Choices

Please grade any dietary selection that is appropriate for you using the following scale:

FD – I consume this a few times per day
FW – I consume this a few times per week
FM – I consume this a few times per month
M – I consume this monthly
D – I consume this once per day
W – I consume this once a week
O – I do not consume this

_____Alcohol	_____ Diet Foods	_____Soft drinks
_____ Tobacco	_____Dairy (milk products)	_____Fast food
_____Coffee	_____Refined Sugar	_____Processed/Packaged
_____ Breads, pastas	_____Artificial Sweeteners	

The type of diet I usually follow is classified as:_____

General Emotional Trauma:

With each of the following potentially stressful situations, please mark either "P" for past or "C" for current.

	Mild	Moderate	Extreme		Mild	Moderate	Extreme
Childhood stress	_____	_____	_____	Change in vocation	_____	_____	_____
School stress	_____	_____	_____	Financial Stress	_____	_____	_____
Family stress	_____	_____	_____	Change in lifestyle	_____	_____	_____
Personal relationships	_____	_____	_____	Stress of being sick	_____	_____	_____
Work related stress	_____	_____	_____	Abuse	_____	_____	_____

Please check any of the stress coping techniques you currently use:

O Exercise ONature ODeep breathing OYoga OMeditation OReading
O Prayer OMusic OCounselling OLife Coach OBodywork
O Other _____

Commitments

How do you grade your physical health?

□ Excellent □ Good □ Fair □ Poor □ Getting better □ Getting worse

How do you grade your biochemical health?

□ Excellent □ Good □ Fair □ Poor □ Getting better □ Getting worse

How do you grade your psychological / emotional health?

□ Excellent □ Good □ Fair □ Poor □ Getting better □ Getting worse

In addition to your main reason for your visit today, what additional health goals do you have for your future?

_____

_____

Is there anything else you would like to bring to our attention? _____

_____