Oakville Chiropractic Life Centre

Dr. Sebastian Guarnaccia, B Sc. (H.K.), D.C.
1-1500 Heritage Way Oakville, ON L6M 3H4
905-825-9529 www.oakvillechiro.com

Adult Health Questionnaire

Name_____ Date_____
Address_____ City_____
Postal Code_____
H.Phone_____ Cell#_____ W#_____
Email: _____ Date of Birth_____
Occupation_____ Number of children and Ages_____
Marital Status: M W S D Referred by_____
Have you seen a chiropractor before? When? _____
How was your experience? _____
Preferred method of contact: _____

About Your Health

You were born to be healthy! Unfortunately your health, your Innate Intelligence, can be interfered with. As Deepak Chopra M.D., has discovered, "All disease results from the disruption of the flow of intelligence." Chiropractic removes this interference when it happens in the spine (vertebral subluxation) so you can express your natural health potential throughout life.

1a. Is this a wellness check-up?
_____

b. What is your major complaint? Please describe?
_____
_____
_____

c. Is the condition interfering with work?____ sleep?____ hobbies?__

d. Have you consulted anyone else for this condition?
_____

e. Have you tried anything to get rid of this problem?
_____

f. Other symptoms you have experienced in the last 6 months: (please circle)

Headaches	Pins & needles leg	Loss of smell
Neck	Pins & needles arm	Loss of taste
Sleeping problems	Numbness in toes	Diarrhea
Back pain	Shortness of breath	Feet cold
Nervousness	Fatigue	Hands cold
Tension	Depression	Stomach upset
Irritability	Constipation	Dizziness
Chest pain	Cold sweats	Ears ring
Loss of memory	Fever	
Loss of balance	Fainting	

ADDITIONAL INFORMATION:_____
_____
_____
_____
_____
_____

History of heart disease____ diabetes___ cancer___ hypertension_____
Allergies:_____

2. **Birth Process** (Please fill out to the best of your knowledge)

Was your delivery long? _____
Was your delivery difficult? _____
Forceps/Vacuum extraction? _____
Caesarean? _____
Breach/Cephalic? _____
Home/Hospital birth? _____
Mother given drugs during delivery? _____
Was labor induced? _____

3. **Growth & Development** (Please fill out to the best of your knowledge)

Were you breast fed? _____
Childhood sickness? _____
Accidents? _____
Surgery? _____
Drugs? _____
Any falls? _____
Did you have other traumas? What? When? _____
_____

4. **Current Health Habits**

Did/do you smoke? _____
Did/do you drink any alcohol? _____
Diet (do you eat healthy foods)? _____
Have you been involved in any car accidents? When? _____
_____
Have you had surgery or organs removed or replaced?
_____
Drugs? (prescription or non-prescription)_____
_____
_____
Supplements?_____
Teeth problems? _____
Eye problems? _____
Hearing problems? _____
Exercise regular? _____
Sleeping habits (nightmares)? _____
Did/do you have occupational stress? _____
Physical stress? _____
Mental stress? _____
Hobbies/Sports injuries? _____
Sleeping posture? _____
Any chance of pregnancy? Yes No
Date of last menstrual cycle?

About Your Care

Chiropractic provides three types of care. The first is **Initial Intensive Care**, which corrects the most recent layer of Spinal and Neurological damage (VSC). This care usually reduces or eliminates the symptoms. Then begins **Reconstructive Care** which corrects the years of damage that occurred to your spine. **Wellness Care** is continued care to keep your body as healthy as possible. This will all be explained at your report of findings. Then you'll be able to begin a course of care that fits your health goals.

Examination Fees

Consultation	--------Complimentary---------
Examination	$60.00 --X-rays- Full Spine $82.00 if required.

Patient Signature_____ Date_____