Oakville Chiropractic Life Centre

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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?

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1b. What is your major complaint? Please describe?

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1c. Is the condition interfering with work?___ sleep?_____ hobbies?__________

1d. Have you consulted anyone else for this condition?

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1e. Have you tried anything to get rid of this problem?

____

1f. 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: ____

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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? __________________________

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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? _________________

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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	$80.00 --X-rays- Full Spine $98.00 if required.
Adjustments	$50
Children/Student	$42

Patient Signature____________________________________ Date______________