

Oakville Chiropractic Life Centre

Dr. Sebastian Guarnaccia, D.C., B.Sc. (H.K)

1-1500 Heritage Way Oakville, ON L6M 3H4

905-825-9529 www.oakvillechiro.com

Health Questionnaire

Name _____ Date _____
Address _____ City _____
Postal Code _____
Priority tel.# _____ other _____
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. **Your Birth** (Please fill out to the best of your knowledge)

Was your delivery long? _____
Was your delivery difficult? _____
Forceps/Vacuum extraction? _____
Cesarean? _____
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	\$80.00 -- X-rays (if applicable) \$98.00
Adjustments	\$54.00 (Children/student \$ 46.00)

Patient Signature _____ Date _____