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?
____

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____________________