Dr. Barbara Sloat
286 Wilson St E
Ancaster, Ont | L9G 2B9

YOUR HEALTH PROFILE

Date _____

PERSONAL INFORMATION

Name _____ Sex M ☐ F ☐ Age _____ Birth Date _____

Address _____ City _____ Postal Code _____

Telephone Res _____ Bus _____ Health Card # _____ Ver Code _____

Employer _____ Occupation _____

Address _____ Do you have Ext. Health Care? Yes ☐ No ☐ Not sure ☐

Marital Status M ☐ S ☐ W ☐ D ☐ CL ☐ Spouse's Name _____ Parent's Name (if under 18) _____

No of Children _____ Names _____ Referred By: _____

Have you ever had previous chiropractic care? Y ☐ N ☐ When? _____ With Whom? _____

Medical Doctor _____ Date of Last Visit _____

Are there recent X-Rays available? Y ☐ N ☐ Where? _____

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This form will help uncover the layers of damage, primarily to your nervous system, which have resulted in less that optimum health.

Following your Chiropractic examination, we will outline a course of care to allow your body to begin correcting these layers of damage so you can recover your natural innate health potential.

ADDRESSING THE ISSUE THAT BROUGHT YOU TO OUR OFFICE:

If you have no symptoms or complaints, and are here for wellness services, please check here ☐
If you are symptomatic, please complete the following:

- Where does it hurt? _____
- How long have you had this? _____
- Have you ever had this before? Y ☐ N ☐ If yes, when? _____
- Is the problem there - all the time ☐ comes and goes ☐ • Is the problem getting - worse ☐ no change ☐ better ☐
- Does the pain travel anywhere? _____
- Please describe how the pain feels: _____
- Any pain at night? Y ☐ N ☐ Does the pain effect the quality of your sleep? Y ☐ N ☐
- Does coughing, sneezing or straining aggravate the pain? Y ☐ N ☐
- What makes it worse? _____ What makes it better? _____

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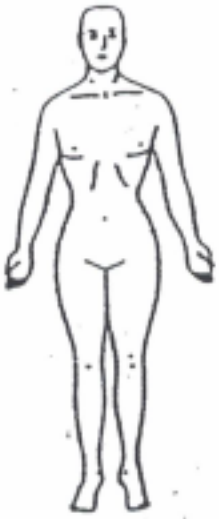
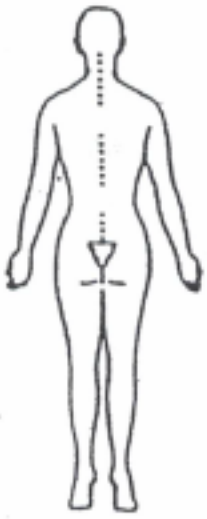
- Please indicate the amount of pain/discomfort associated with your problem(s)



no pain 1---1---1---1---1---1---1---1---1---1---1 worst pain ever
0 1 2 3 4 5 6 7 8 9 10

Please use the symbols below to mark
and describe each type of problem
on the body diagrams.

Sharp/stabbing pain XXXX
Dull ache OOOO
Numbness .....
Stiff/tightness ////
Tingling ****
Burning ++++



HAVE YOU EVER:

Had an accident (car, fall, sports, other)? Y ☐ N ☐ Describe:_____

_____

Had an operation? Y ☐ N ☐ Describe:_____

Had a fracture? Y ☐ N ☐ Describe:_____

Been hospitalized? Y ☐ N ☐ Describe:_____

FAMILY HISTORY

	Back Pain	Headaches	Arthritis	Cancer	Heart	Diabetes
Mother	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

Please describe other:

_____

_____

ARE YOU TAKING ANY OF THE FOLLOWING?

Anti-inflammatories ☐ Sedatives ☐ Muscle relaxants ☐
Antibiotics ☐ Aspirin/Analgesics ☐ Birth control pills ☐
Insulin ☐ Antacids ☐ Vitamins/Herbs ☐ Other: _____

LIFE STYLES:

Smoking _____ packs/day Alcohol _____ drinks/week Coffee/tea/caffeinated beverage _____ cups/day

Exercise _____ times/week Sleep _____ hours/day on back ☐ side ☐ stomach ☐

Your stress level can be described as : minimal ☐ moderate ☐ severe ☐ intolerable ☐

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PLEASE CHECK FOR ANY CONDITIONS PAST/PRESENT:

	Present	Past
headaches	☐	☐
fever	☐	☐
fainting dizziness	☐	☐
loss of sleep	☐	☐
loss of weight	☐	☐
convulsions	☐	☐
nervousness	☐	☐
poor concentration/memory	☐	☐
chest pain	☐	☐
high/low blood pressure	☐	☐
stroke	☐	☐
difficulty breathing	☐	☐
chronic cough	☐	☐
nausea	☐	☐
vomiting	☐	☐
heartburn	☐	☐
ulcer	☐	☐
belching or gas	☐	☐

	Present	Past
neck pain/stiffness	☐	☐
back pain		
pain between shoulders	☐	☐
pain or numbness in arms, hands, legs, feet	☐	☐
bursitis	☐	☐
arthritis	☐	☐
swollen feet	☐	☐
spinal curvature	☐	☐
appetite changes	☐	☐
excessive thirst	☐	☐
constipation/diarrhea	☐	☐
jaundice	☐	☐
gall bladder trouble	☐	☐
colitis	☐	☐
hemorrhoids	☐	☐
black/bloody stools	☐	☐
changes in bowel or bladder habits	☐	☐
thyroid problems	☐	☐

	Present	Past
blurred/failing vision	☐	☐
deafness	☐	☐
earaches	☐	☐
sore throat	☐	☐
hoarseness	☐	☐
difficulty swallowing	☐	☐
frequent colds	☐	☐
sinus infections	☐	☐
asthma	☐	☐
allergies	☐	☐
kidney infections/stones	☐	☐
problems with urination	☐	☐
blood in urine	☐	☐
bed wetting	☐	☐
infertility	☐	☐
sexual dysfunction	☐	☐

Women Only:

	Present	Past
excessive menstruation	☐	☐
irregular cycle	☐	☐
hot flashes	☐	☐
breast pain/lumps	☐	☐

CONDITIONS:

☐ osteoporosis ☐ fibromyalgia ☐ eczema/skin problems ☐ diabetes
☐ other (please specify)

_____

_____

ARE YOU WEARING:

heel lifts ☐ sole lifts ☐ inner soles ☐ arch supports ☐ orthotics ☐

What do you hope to do better and enjoy more as a result of the improved health you will gain from Chiropractic care?

_____

_____

_____

_____

_____

Signature _____ Date _____

please turn to back page to complete

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People go to a Chiropractor for a variety of reasons. Please indicate the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ **Preventative care** – *I want my body to be brought to the highest state of health possible with Chiropractic care.*
- ☐ **Corrective Care** – *I want to have the cause of the problem as well as the symptoms corrected and relieved.*
- ☐ **Relief Care** – *I want symptomatic relief of this condition only.*
- ☐

The Doctor of the future
will give no medicine
but will interest his patients
in the care of the human frame,
in diet, and in the cause and
prevention of disease.

Thomas Edison