DIXIE DUNDAS CHIROPRACTIC & ACUPUNCTURE CLINIC

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YOUR HEALTH PROFILE

Please fill out the following 2 pages. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Section A: Your Information

Last Name: _________________________ First Name: _____________________________ Middle Initial: ______

Mailing Address: ____ City: __________________________

Postal Code: _____________________ E-mail: ____

Birth date: M______ D______ YR________ Age: ______ Male ☐ Female ☐ Is there any chance you are pregnant? Yes ☐ No ☐

Home Telephone: (____)______________________ Cell: (____)_____________________ Work: (____)_______________Ext:______

Single ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Widowed ☐ # of Children: ____________________

Business / Employer: _______________________________________ Type of Work: _______________________________________

How did you hear about our office? (If someone referred you, please let us know so that we can thank them!)

____

Section B: Your Current Health

Check any of the following symptoms or health challenges you have had in the last 12 months, even if they do not seem related to your current problem.

☐ LOW BACK PAIN ☐ HEADACHES/MIGRAINES ☐ TIRED/FATIGUE ☐ CANCER

☐ SCIATICA ☐ NUMBNESS/TINGLING ☐ DIGESTIVE PROBLEMS ☐ DIABETES

☐ SHOULDER PAIN ☐ KNEE/ANKLE/FOOT PAIN ☐ VARICOSE VEINS ☐ ASTHMA

☐ ELBOW PAIN ☐ RINGING IN THE EARS ☐ ALLERGIES/SINUS ☐ COMMON COLDS/FLUS

☐ WRIST/HAND PAIN ☐ DIZZINESS ☐ INFERTILITY ☐ WEIGHT LOSS/OBESITY

☐ NECK PAIN ☐ TENDONITIS/ARTHRITIS ☐ DIFFICULTY SLEEPING ☐ DEPRESSION

☐ HEART DISEASE/PACEMAKER ☐ PAIN/TENSION BETWEEN THE SHOULDER BLADES

☐ HIGH/LOW BLOOD PRESSURE ☐ FLAT FEET/PLANTAR FASCITIS/CALLUSES/BUNIONS

☐ PAINFUL MENSTRUATION/CRAMPING (women) ☐ MENOPAUSE (women) ☐ PROSTATE (men)

OTHER: ____

Which of the above is the worst? ___________________________________ How long have you had it? _____________

Does it interfere with: ☐ Work ☐ Sleep ☐ Family ☐ Social

Other professionals seen for this problem: ☐ Chiropractor ☐ physiotherapist ☐ MD ☐ Other__________________

Does anyone else in your family suffer from any of the above conditions? _______________________________________

Section C: Family Physician & Private Health Insurance

Family Physician's Name: ______________________________________ Phone #: (_____)________________________

Do you have private health insurance / extended health care? ☐ Yes ☐ No

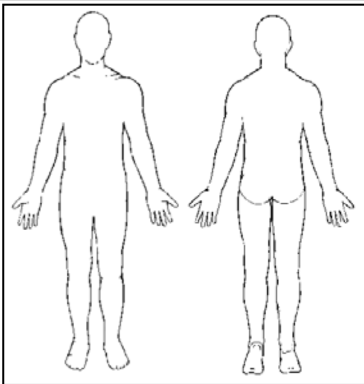
Company Name: ____

Section D: Growth / Development & Current Health Habits

	Yes	No	Details
Medications?	☐	☐	______________________________
Surgery?	☐	☐	______________________________
Do/Did you smoke?	☐	☐	______________________________
Do/Did you drink alcohol?	☐	☐	______________________________
Have you been in any accidents?	☐	☐	______________________________
Were you under chiropractic care as a child?	☐	☐	______________________________
Do/Did you play any sports?	☐	☐	______________________________
Are you presently physically active?	☐	☐	______________________________
Are you interested in becoming more active?	☐	☐	______________________________

Please Circle One:

Stress Level	High	Moderate	Low
Diet	Excellent	Good	Poor
Sleep	Excellent	Good	Poor
General Health	Excellent	Good	Poor



Mark where the problem is and please describe what it feels like.

Sharp / Dull / Achy / Stabbing

____

____

____

Is this condition ☐ Job related / WSIB ☐ Motor Vehicle Accident

(**If so, PLEASE INFORM THE FRONT DESK**)

Section E: History of Care Received

Have you ever received any of the following type of care before?

Chiropractic care ☐ If yes, how long ago? ________________ Chiropractor's Name: __________________________

Massage therapy ☐ Date of last treatment: __________ Acupuncture ☐ Date of last treatment: _________

Section F: Your Expectations

What do you look for in a good doctor? ____

What do you expect from your office visit? ____

When dealing with a problem/health issue how do you get rid of the problem?

☐ Only symptomatic relief ☐ Symptomatic relief & prevention of re-occurrence

☐ Symptomatic relief, prevention of re-occurrence and achievement of optimal wellness

I confirm that all of the above information I have indicated is true and accurate to the best of my knowledge.

_________________________ _________________________ _________________________

Printed Name **Signature** **Date**