Progressive Family Wellness Centre

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www.progressivewellness.ca

CONFIDENTIAL APPLICATION FOR CARE

Personal Information

Name: _____ Date: _____

Address: _____ Home Phone: _____

City, Province, Postal Code: _____ Work Phone: _____

Email Address: _____ Cell Phone: _____

Best time/place to contact you: _____

Occupation: _____ Employer: _____

Date of Birth: _____ Age: _____ Gender: ❑ Male ❑ Female Height:_____ Weight_____ Shoe Size:____

Marital Status: ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed ❑Common Law/Serious Relationship ❑Engaged

Name of Spouse / Significant Other: _____

Number of Children: _____Names & Ages:_____

Do you have extended health coverage? ❑Yes ❑No Annual Chiropractic Coverage_____ Orthotics_____

Previous Chiropractic Care? ❑Yes ❑No Doctors name:_____

Who may we thank for referring you? _____

History of Complaint

Please identify the condition(s) that brought you into this office: Primary:_____

Secondary:_____ Third:_____ Fourth:_____

On a scale of **1 -10** with **10** being the worst and **zero** being no pain, rate your above complaints by ***circling the number:***

Primary or Chief Complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Second Complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Third Complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Fourth Complaint is: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

When did the problem(s) begin? _____ When is it at its worst? ❑AM ❑Mid Day ❑PM ❑Late PM

How long does it last? ❑Constant ❑Off and On During the Day ❑It Comes and Goes Through the Week

What aggravates your symptoms? ❑Sitting ❑Standing ❑Bending ❑Lifting ❑Walking ❑Lying Down ❑Nothing ❑Other _____

What relieves your symptoms? ❑Rest ❑Ice ❑Heat ❑Massage ❑Medication ❑Movement ❑Nothing ❑Other:_____

Character of Pain: ❑Sharp ❑Dull ❑Ache ❑Burn ❑Throb ❑Spasm ❑Numb ❑Tingling ❑Shooting ❑Sore ❑Stabbing

Spinal stress can also **choke the nerves** and cause the pain to **travel** to different parts of the body. For example, neck pain can travel down into the shoulders/arms, low back pain can travel down into the legs. Have you experienced any travelling pain ? ❑Yes ❑No

Does the pain travel into your: ❑Arm/Shoulder ❑Leg ❑Does Not Travel Is this condition getting worse? ❑Yes ❑No ❑Same

Does this complaint interfere with: ❑Work ❑Sleep ❑Hobbies ❑Family Activities ❑Daily Routine ❑Sports/Exercise

How has it affected your life? What are you hoping to improve in your life with chiropractic care? That is, what would you like to start doing if you were feeling 100%?_____

If you don't get the problem corrected, do you think it will get worse over the next 5 years? ❑Yes ❑No

How committed are you to achieving optimal health?

Not Committed — Moderately Committed — 100% Committed

1 2 3 4 5 6 7 8 9 10

What is most important to you in a relationship with our clinic? **(Please check only one)**

❑Time ❑Trust/Honest ❑Communication ❑Finances ❑Results ❑Friendliness ❑ Other_____

Identify any other injuries to your spine, minor or major, that the doctor should know about: _____

_____

Past History

Have you suffered with this or a similar problem in the past? ❑Yes ❑No If yes, how many times?_____
When was the last episode? _____ How did the injury happen? _____

Other forms of treatment tried: ❑Yes ❑No If yes, please state what type of treatment:_____
When?_____ Results:_____

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body:

_____

Accidents / Injuries

Car Accidents (please list all)

Year:_____ Injury:_____ Treatment:_____
Year:_____ Injury:_____ Treatment:_____
Year:_____ Injury:_____ Treatment:_____

Sports Injuries (please list all)

Year:_____ Injury:_____ Treatment:_____
Year:_____ Injury:_____ Treatment:_____
Year:_____ Injury:_____ Treatment:_____

Falls: (please list all)

Year:_____ Injury:_____ Treatment:_____
Year:_____ Injury:_____ Treatment:_____
Year:_____ Injury:_____ Treatment:_____

Please list any major operations/illnesses you've had and their approximate dates.

_____

_____

_____

Social History

Smoking: ❑Cigars ❑Pipe ❑Cigarettes ❑Daily ❑Weekends ❑Occasionally ❑Never
Alcoholic Beverages: Consumption occurs: ❑Daily ❑Weekends ❑Occasionally ❑Never
Recreational Drug Use: ❑Daily ❑Weekends ❑Occasionally ❑Never

Family History

Does anyone in your family suffer with the same condition(s)? ❑Yes ❑No
If yes, whom? ❑Father ❑Mother ❑Sister ❑Brother ❑Grandmother ❑Grandfather ❑Son(s) ❑Daughter(s)
Have they ever been treated for their condition? ❑Yes ❑No ❑I don't know

Are there any other hereditary conditions the doctor should be aware of? _____

General Health History:

Current Medicines and Vitamins/Supplements:

- ❑ Painkillers _____
- ❑ Muscle relaxants _____
- ❑ Stimulants, Anti-depressants _____
- ❑ Blood Thinners _____
- ❑ Insulin _____
- ❑ Other _____
- ❑ Anti-inflammatory _____
- ❑ Blood pressure _____
- ❑ Tranquilizers, anti-anxiety _____
- ❑ Birth control pills _____
- ❑ Vitamins/Supplements _____

Research has shown that nerve interference, causing stress to your nerves, will weaken and distort the function of your nervous system and body, and adversely affect your overall health. Please **check [✔]** the box for symptoms you are **currently experiencing** and **mark an [X]** for symptoms you've **experienced in the past**.

Cranial and Cervical Nerves

- ❑ Neck Pain
- ❑ Pain into your shoulders/arms/hands
- ❑ Numbness/tingling in arms/hands
- ❑ Hearing disturbances
- ❑ Ringing in ears
- ❑ Weakness in grip
- ❑ Headaches
- ❑ Dizziness
- ❑ Visual disturbances
- ❑ Coldness in hands
- ❑ Thyroid conditions
- ❑ Sinusitis
- ❑ Allergies/hay fever
- ❑ Frequent colds/flu
- ❑ Low energy/fatigue
- ❑ TMJ pain/clicking
- ❑ Earaches
- ❑ Loss of sleep
- ❑ Anxiety/Depression
- ❑ Lightheadedness

Upper Thoracic Nerves

- ❑ Upper back pain
- ❑ Heart palpitations
- ❑ Heart murmurs
- ❑ Tachycardia
- ❑ Heart attacks/angina
- ❑ Recurrent lung infections/bronchitis
- ❑ Asthma/wheezing
- ❑ Shortness of breath
- ❑ Pain on deep inspiration/expiration

Women Only:

- ❑ Menstrual cramps
- ❑ Excessive menstruation
- ❑ Irregular cycle
- ❑ Hot flashes

Are you pregnant?
Yes ❑ No ❑

Lower Thoracic Nerves

- ❑ Mid back pain
- ❑ Pain into your ribs/chest
- ❑ Indigestion/heartburn
- ❑ Reflux
- ❑ Nausea
- ❑ Ulcers/gastritis
- ❑ Hypoglycemia
- ❑ Tired/irritable after eating or when you haven't eaten for a while
- ❑ Skin disturbances
- ❑ Abdominal bloating
- ❑ Ulcerative intestinal conditions

General Conditions:

- ❑ Stroke
- ❑ Heart Disease
- ❑ Cancer
- ❑ Diabetes

Lumbar and Sacral Nerves

- ❑ Pain into your hips/legs/feet
- ❑ Numbness/tingling in your legs/feet
- ❑ Coldness in legs/feet
- ❑ Muscle cramps in your legs/feet
- ❑ Constipation/diarrhea
- ❑ Weakness/injuries in your hips/knees/ankles
- ❑ Recurrent bladder infections
- ❑ Frequent/difficulty urinating
- ❑ Sexual dysfunction
- ❑ Low back pain

Is there anything else which may help us to better understand you, which has not been discussed? ❑ Yes ❑ No

_____

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients of benefits and risks including sprain/strain, rib fracture, disc herniation and with neck problems the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or stroke like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays have been performed on you to minimize these risks to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions about this, please ask your chiropractor.

I have read the above statement and consent to treatment.

Signature: _____ Date: _____

Activities of Daily Living - Effects of Current Condition on Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life.

Bending	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Concentrating	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing computer Work	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Gardening	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Playing Sports	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Recreation Activities	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Shoveling	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sleeping	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Watching TV	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Carrying	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dancing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Dressing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Lifting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Pushing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Rolling Over	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Working	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Climbing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Doing Chores	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Driving	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Performing Sexual Activity	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Reading	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Running	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Sitting to Standing	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Walking	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform
Other	☐ No Effect	☐ Painful (can do)	☐ Painful (Limits)	☐ Unable to Perform

Initial Nutritional Profile

Have you tested with high triglycerides or high cholesterol? ❑Yes ❑No Values _____
Have you tested with high blood pressure? ❑Yes ❑No
Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? ❑Yes ❑No
Do you eat breakfast daily from Monday to Friday? ❑Yes ❑No
How many days per week do you skip one meal? (please circle) 1 2 3 4+
How many fast food, refined foods or pre-prepared meals to you eat per week? (please circle) 0 1-3 4-6 7+
How many servings of fruit do you have on a given day? (please circle) 0 -1 2-3 4-5
How many servings of vegetables do you have on a given day? (please circle) 0 -1 2-3 4-5
Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

Diet Pop Coffee Juice Milk Pop Alcohol

Please list any supplements you take regularly: _____
_____

Initial Fitness Profile

How many days per week do you exercise?
Cardio: ____hours ____days/wk
Weight Training ____hours ____days/wk
Low Impact (yoga etc.) ____hours ____days/wk
What is your target weight? _____ What is your current weight? _____
How willing are you to change any of these things to reach your health goals? **(Scale of 1-10)** _____

Initial Toxicity Profile

Are you regularly exposed to cleaning products or industrial chemicals? ❑Yes ❑No
Have you ever noticed mold growing your home or place of work? ❑Yes ❑No
Does your home, work, school or car have a damp or mildew smell? ❑Yes ❑No
Have you received a full standard profile of vaccinations? ❑Yes ❑No
Do you receive yearly flu shots? ❑Yes ❑No
How many flu shots have you received? _____ (estimate)
Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? ❑Yes ❑No
Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? ❑Yes ❑No

Initial Stress Profile

Do you get an average of 8 hours of sleep per night? ❑Yes ❑No
Do you average less than 7 hours of sleep per night? ❑Yes ❑No
Do you ever take pills to go to sleep or relax? ❑Yes ❑No
Do you often feel short on time and procrastinate on projects? ❑Yes ❑No
Do you experience feelings of anxiety about completing tasks? ❑Yes ❑No
Do you feel like you don't give enough time or attention to important areas in your life, like family, personal growth or hobby? ❑Yes ❑No
Do you rely more on your memory than a planner and action list to get things done? ❑Yes ❑No
Do you take time to pray, meditate, or visualize on a regular basis? ❑Yes ❑No