JOHNSON CHIROPRACTIC CLINIC
102-130 Sproule Rd
Perth, ON ~ K7H 3C9
(613) 264-2402 ~ fax (613) 264-2410

Adult Health Profile

Patient # _____

Name: _____

Date of Birth dd _____/mm_____/ yy_____

Address: _____

_____

(please circle) Married Single Common Law Divorced Widowed

Phone: (home) _____ Spouse's name: _____

(work) _____ Do you have children? _____ How many? _____

Employer: _____ Children's names _____

Your occupation: _____ MD _____

Emergency Contact person: _____ Phone # _____

Have you ever received chiropractic care? yes no

If yes by whom: _____ When? _____

How did you discover the Johnson Chiropractic Clinic? _____

Why this form is important:

Our office focuses on your ability to be healthy. Our goals are to first address the issues that brought you to this office, and second, offer the opportunity to improve your health potential in the future. In order to give you the best possible chiropractic care, we will need to discover any stresses that are placed on your body. Please take the time to fill out this form completely, as each question gives us a clearer picture of your current health status.

Present reason for consulting our office:

□ Pain relief care only

□ Correction and prevention of existing problem?

□ Maximizing personal and / or family health potential?

Please describe your current problem, if any....

_____

_____

When did this problem start? (Specific date if possible)_____

_____

Does the pain radiate or travel anywhere else? _____

How often do you feel the pain? □ Constant (76 -100%) □ Frequent (51 - 75%)

□ Occasional (26-50%) □ Intermittent (25% or less)

Is the condition worse in □ AM □ PM □ no difference

Is the condition interfering with □ sleep □ work □ routine □ recreation □ other

How bad is your pain or ache? Please circle a number (0 = no pain, 10 = unbearable pain)

0 1 2 3 4 5 6 7 8 9 10

Is condition getting progressively worse? □ Yes □ No □ Staying the same

Pain is ... □ sharp □ dull □ throbbing

□ aching □ shooting □ nagging □ other _____

Aggravated by: □ sitting □ standing □ driving □ getting up after sitting

□ bending □ stairs □ lifting □ coughing/sneezing

□ bowel movements □ Other _____

Relieved by: □ activity □ rest □ ice □ heat

□ standing □ sitting □ medication (name) _____

Have you had x-rays, CT Scans, or MRI's or ultrasound taken ? □ yes □ no

If yes.... when? _____ Where? _____

Current or past conditions: (✓ all that apply)

□ Diabetes □ Blood pressure high/low □ Stroke □ Cancer _____

□ Depression □ Anxiety □ Arthritis □ Irregular Bowels

□ Crohn's/IBS □ Dizziness □ Infertility □ Infections _____

□ Vision trouble □ Hearing trouble □ Urinary problem □ Sexual Dysfunction

□ Hemorrhoids □ Thyroid trouble □ Heartburn □ Difficulty breathing

□ Menstrual problems

List any and all medication you are currently taking:_____

_____

Please list any herbs, nutritional supplements or natural home remedies you take regularly: _____

_____

List any surgeries and include when? _____

_____

Please describe any falls, auto accidents or major injuries (include month/year, type of accident)

_____

_____

Is there a family history of: (✓ all that apply)

	Heart Disease	**Stroke**	**Cancer**	**Arthritis**	**Diabetes**	**Other**
Mother	□	□	□	□	□	□ _____
Father	□	□	□	□	□	□ _____
Brother(s)	□	□	□	□	□	□ _____
Sister(s)	□	□	□	□	□	□ _____

Are you wearing: □ heel lifts □ sole lifts □ inner soles □ arch supports □ orthotics

Do you use: □ coffee □ tea □ artificial sweeteners

□ alcohol □ cigarettes □ recreational drugs

I learn best by:

□ Hearing □ Reading □ Doing

How would you rate your health: (circle the number that best describes how you are feeling)

Yuck...I've never felt worse Wow I feel great!

1 2 3 4 5 6 7 8 9 10

How committed are you to improving your health:

Nah, not important I want to be 100% healthy

1 2 3 4 5 6 7 8 9 10

Do you want to live to be a healthy 85 years old? □ Yes □ No

What is being healthy to you (✓ all that apply)?

□ Not being sick □ Being symptom free

□ Having energy to do what I want, when I want □ Not needing to take time off work

□ To fully enjoy all aspects of life to the fullest extent possible

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

_____

_____

Email: _____

I give **express consent** to Johnson Chiropractic Clinic for email contact such as birthday greetings, to notify me of special offers, events & our newsletter. I can withdraw my consent at any time. This consent does not apply to statements, reminders or appointments lists, these notifications are covered under implied consent and do not need express consent.

_____ _____

Patient's signature *Date*

(If you are completing this online please complete the Wellness check)

PATIENT ALLERGY/SENSITIVITY SURVEY

Check any of these you believe may be causing you any problems:

□ Shell Fish
□ Wine, Beer, Alcohol
□ Fruits / Berries, Nuts
□ Bed Wetting
□ Eggs, Grains
□ Animal Dander, Feathers, Fur
□ Nightshades (tomatoes, potatoes, peppers)
□ Fabrics, Upholstery, Plastics
□ Skin issues, Acne, Eczema, Psoriasis
□ Laundry Detergents, Softeners
□ Dairy (milk, cheese, yogurt, etc.)
□ Asthma, Breathing issues
□ Lack of Energy
□ Sleep Issues
□ Coffee, Chocolate, Tea, (caffeine)
□ Anxiety/Stress issues
□ Perfumes, Candles, Oils, Shampoo, Makeup
□ Nutritional Supplements/Herbal Remedies
□ Environmental (pollen, grass, Trees, mold)
□ Metals _____
□ Stinging Insects
□ Seasonal Allergies
□ Focus, Concentration, Memory Issues
□ Emotional Upset/Traumas_____
□ Chemicals, Latex_____
□ Other _____
□ Digestive Issues, Bloating, Gas,
□ Performance Issues_____

Please answer the following questions about the above substances:
Which of the above causes you the most trouble? _____
_____

On the 1-10 scale below, how would you rate your discomfort from this allergy/sensitivity, when it's at its worst?
Mild 1 2 3 4 5 6 7 8 9 10 **Severe**

How long have you been suffering with this allergy/sensitivity problem?
_____weeks _____months _____years

How does this allergy/sensitivity condition affect your ability to perform daily tasks (check one)
□ No major impact – I get along fine
□ It bothers me – but I just carry on
□ It bothers me – slows me down, sometimes
□ It's an occasional problem – but when it's bad, it's really bad
□ It bothers me all the time – it can stop me from doing things I want to do
□ I'm desperate – I need help

Would you like to eliminate or reduce this allergy/sensitivity this problem? □ Yes □ No
If you Smoke, would you like to quit? □ Yes □ No
If Yes, Why?_____

We offer an advanced program to reduce or eliminate many of the allergies and sensitivity issues you and/or your family members may be experiencing.
Please let us know if you would like to receive more information.