JOHNSON CHIROPRACTIC CLINIC
Dr. Kelly Johnson, B.Sc. (Hon), D.C.
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Perth, ON ~ K7H 3C9
(613) 264-2402 ~ fax (613) 264-2410

Teen Health Profile

Patient # _____

Date: _____ Name: _____

Address: _____ Phone: (*home)* _____

_____ *(work)* _____

Date of Birth _____ Occupation: _____

Marital Status: single married divorced separated widowed other

Children: yes no How many? _____

How did you discover the Johnson Chiropractic Clinic? _____

If referred, the name of the person who referred you: _____

Please complete this general health history survey, as it will provide your doctor with information to better understand your history, your present and long term needs.

Part 1: Your Health Concerns

1. What is the reason you have come to our office today? _____
2. When did this situation or concern begin? _____
3. Have you done anything about this situation or concern or obtained any advice or treatment for it? ..... Yes No
4. If yes, what were you told? _____
5. What was done? _____
6. Did that seem to work? _____
7. How aware of this are you during the day? 0 1 2 3 at night? 0 1 2 3
   0 - not aware, 1 - slightly aware, 2 - mostly aware, 3 - always aware
8. Is there any time, or activity you can be involved with when you totally or almost forget about this condition, symptom or concern? _____
9. Is there any time of day or activity which makes you aware of it? _____
10. What are you doing in your life now that is different from what you would be doing if you did not have this condition/symptom? _____

Part 2: Health/Trauma/Medical/Chiropractic and Healing History

1. Have you ever injured your spine (neck, head, back, hips)? ..... Yes No
   Date of most significant injury: _____
   What happened? _____
   Date of most recent injury: _____
   What happened? _____
2. Have you had a work/vehicular accident related injury? ..... Yes No
   Please describe _____
3. Please list medications (prescription or non-prescription) you have taken within the past 60 days:

   _____
4. In the past, have you taken other medications for a period of more than 3 months ..... Yes No
   What did you take? _____
   What was the reason for taking this medication? _____

Name: _____

5. Have you had any spinal x-rays, cat scans or MRI of your spine or head? ..... Yes No

If yes...when? _____ where? _____

What were you told about them? _____

6. Have you had any surgeries? Please explain _____

7. Have you broken any bones, or significantly sprained part of your body? ..... Yes No

Please explain _____

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

9. Has your spine ever been professionally adjusted by a chiropractor? ..... Yes No

By whom? _____ When? _____

Why did you go? _____

Are you still going? Yes No

Were you pleased? Yes No

Does your family receive chiropractic care? Yes No

10. Describe your regular exercise and leisure activities _____

11. How many hours of sleep do you get per night? _____ what hours? From _____ to _____

Do you have any difficulty falling to sleep ..... Yes No

Do you often nap or feel sleepy during the day? ..... Yes No

Do you awaken refreshed and rested ..... Yes No

12. Describe a typical day's diet, including snacks and drinks: _____

If possible (if it was a typical day) list what you had to eat yesterday: _____

Do you crave any certain foods (or flavour) on a regular basis?

If yes, please list _____

13. What is your daily intake?

Water _____ ounces Coffee (or other caffeinated drinks) _____ ounces

Alcohol _____ ounces - type (beer, wines, liquor) _____

Tobacco _____ packs per day - type _____ How long have you been a smoker? _____

Have you quit smoking? _____ when? _____

Recreational drugs: _____ - type _____ quantity _____

Email: _____

I give **express consent** to Johnson Chiropractic Clinic for email contact such as birthday greetings and our newsletter and to notify me of special offers and events. 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)

Name: _____

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.

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