



**Kay  
Chiropractic &  
Wellness Centre**

First Name \_\_\_\_\_ Initial \_\_\_\_\_ Last Name \_\_\_\_\_  
 Address \_\_\_\_\_ Apartment \_\_\_\_\_ Unit# \_\_\_\_\_  
 City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Who referred you to our clinic? \_\_\_\_\_  
 Date of Birth (dd/mm/yy) \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
 Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
 Email Address \_\_\_\_\_

**WHY THIS FORM IS IMPORTANT**

Our office focuses on maximizing health. Our goals are to 1) address the issue that brought you to this office and 2) to offer the opportunity to learn and improve your health potential for the future. Daily activities/stresses/traumas can accumulate and cause damage to your nervous system. This damage builds layer upon layer to a level at which you may not yet be aware. We need to know what your layers of damage contain, so we ask you to carefully fill out this detailed and important form.

Research is showing that many of the health challenges that occur later in life originate during the developmental (early) years of our lives. That's why many parents bring their children in for regular spinal check-ups so that they can be as healthy as possible and prevent future problems. Please be specific as you can with your answers.

<b>THE BEGINNING YEARS OF LIFE (Birth to Age 15)</b>	<b>YES</b>	<b>NO</b>	<b><u>EXPLAIN/COMMENTS:</u></b>
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you fallen/jumped from a height over 3 FT? (crib/bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there any prolonged use of medicine, such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any other traumas? (physical or emotional)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you Vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you under regular chiropractic care as a child?	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>YOUNG ADULT (Age 15 to Present)</b>	<b>YES</b>	<b>NO</b>	<b><u>EXPLAIN/COMMENTS:</u></b>
Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____

On a scale of 1-10 describe your stress level at Work \_\_\_\_\_ Personal Life \_\_\_\_\_ (0=None 10=Extreme)  
 On a scale of Poor, Good, Excellent describe your: Exercise \_\_\_\_\_ Sleep \_\_\_\_\_ Diet \_\_\_\_\_  
 Have you ever been to a Doctor of Chiropractic before?  YES  NO  
 Who? \_\_\_\_\_ Date of last visit \_\_\_\_\_  
 For what reason? \_\_\_\_\_



People who already experienced **Chiropractic Wellness Care** and are here to continue, need only check the box:  
"I wish to continue my Chiropractic Maintenance"

Others need to please complete the following:

**Your Main Complaint:**  
\_\_\_\_\_

On a scale of 1 to 10, with **10 being the highest**, rate your commitment in helping us solve your problem:  
1  2  3  4  5  6  7  8  9  10

Any other complaints: \_\_\_\_\_

How long have you suffered with the main complaint? \_\_\_\_\_

What is the pattern of this problem?  Constant  Intermittent  Occasional  Cyclic

How did it start? \_\_\_\_\_

Could your problem have been caused by an injury at work?  YES  NO

If yes, please give us the details incl. date and how injury happened: \_\_\_\_\_

Have you had previous treatment for your main complaint?  YES  NO

If yes, list treatment: \_\_\_\_\_

What gives you some temporary relief? \_\_\_\_\_

What do you do that makes this problem worse? \_\_\_\_\_

When your problem is at its worst, how does it make you feel? \_\_\_\_\_

What have you tried to do to get rid of this problem that **DID NOT** work? \_\_\_\_\_

Have you become discouraged about handling this problem?  YES  NO

Does experiencing this problem cause stress for you?  YES  NO

How much older does this make you feel? \_\_\_\_\_

Which of the following areas of your life does your problem affect?

WORK:  Explain: \_\_\_\_\_

FAMILY:  Explain: \_\_\_\_\_

HOBBIES:  Explain: \_\_\_\_\_

LIFE:  Explain: \_\_\_\_\_

What of the following activities does your problem prevent you from doing, either partially or totally?

Sleep  Walking  Sitting  Leisure  Work (what is your job? \_\_\_\_\_)

Explain: \_\_\_\_\_

What effect does your problem have on your bodily functions? \_\_\_\_\_

Have you been involved in an auto accident?  YES  NO

If YES, indicate the date and details: \_\_\_\_\_

Do you have any children?  YES  NO; if yes how many \_\_\_\_\_ List their ages: \_\_\_\_\_

Do they have any health conditions that you are aware of?  YES  NO

If yes, what are they? \_\_\_\_\_

Health conditions of immediate family members: \_\_\_\_\_

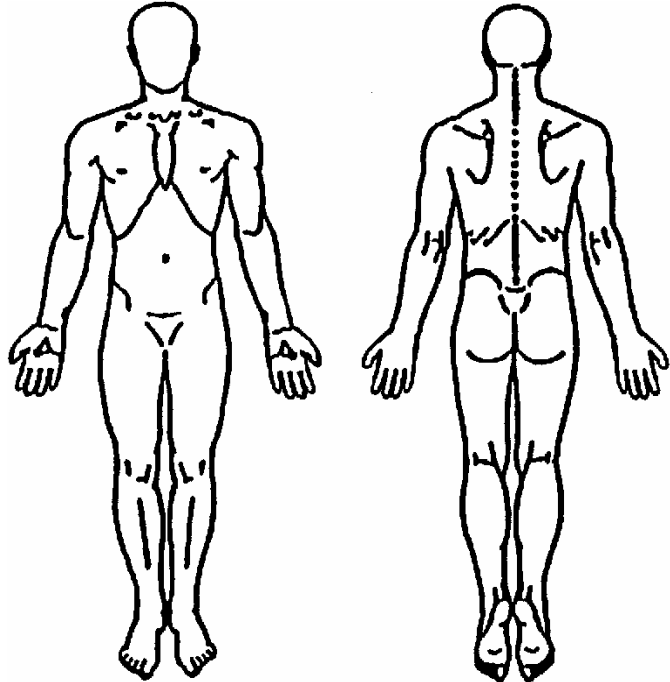


**Location of Pain:**

Please use the following chart to **draw the letter "X"** in the areas that bother you. Next to each of these areas, use the appropriate letter to describe what you feel. (Example: If your hand is numb, draw an "X" in the hand and put "N" next to the hand for numbness).

Legend:

- N** numbness
- P** pain
- T** tingling
- A** ache
- S** soreness
- ST** stiffness



The following symptoms are signs of **nervous system problems**. Please check off all that you presently have or have had in the past even if they do not seem to be related to your current problem.

**O**=Occasional

**F**=Frequent

**C**=Constant

**O F C**

- Headaches
- Pins & Needles in arms
- Pins & Needles in legs
- Numbness in fingers
- Numbness in toes
- Cold hands
- Cold feet
- Buzzing in ears
- Ringing in ears
- Loss of balance
- Dizziness
- Loss of taste

**O F C**

- Loss of smell
- Visual problems
- Constipation
- Diarrhea
- Problems Urinating
- Neck Pain
- Back Pain
- Irritability
- Depression
- Heart Burn
- Ulcers
- Stomach Tension

**O F C**

- Nervousness
- Menstrual pain
- Menstrual irregularity
- Mood Swings
- Fatigue
- Sleeping problems
- Colds/sickness
- Sore throat
- Asthma
- Allergies
- Sweating
- Fainting

**Do you suffer from any of the following?**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Heart condition/Angina | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Endometriosis       | <input type="checkbox"/> Intestinal tract disorder |
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Tendonitis           | <input type="checkbox"/> Hormonal imbalances | <input type="checkbox"/> Indigestion               |
| <input type="checkbox"/> Prostate Condition     | <input type="checkbox"/> Spinal Disc Problems | <input type="checkbox"/> PMS                 | <input type="checkbox"/> Bloating after meals      |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Weak Immune System   | <input type="checkbox"/> Uterine Fibroids    | <input type="checkbox"/> Eczema/Psoriasis          |



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What, if any, surgeries have you ever had? \_\_\_\_\_

Have you ever been diagnosed with any diseases? \_\_\_\_\_

Have you lost more than 20 lbs in the past 90 days?  YES  NO

Who is your family Doctor? \_\_\_\_\_ Phone: \_\_\_\_\_

Please list any medications that you are currently taking: (including aspirin, Tylenol, antihistamines, birth control pills, HRT, etc...)

\_\_\_\_\_

Do you utilize other forms of Holistic health care methods? (Massage Therapy, Naturopathy, Yoga, Acupuncture, Vitamins, Herbs...) \_\_\_\_\_

\_\_\_\_\_

Do you sleep with a special cervical pillow?  YES  NO

Do you use orthotic shoe devices?  YES  NO

**Is there any other information you would like us to know?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For Women Only**

Date of your last menstrual period: \_\_\_\_\_

Are you pregnant?  YES  NO

Are you using any means of contraception? \_\_\_\_\_

Do you experience severe cramping with your menstrual period?  YES  NO

Do you suffer from PMS?  YES  NO

Have you ever miscarried?  YES  NO

**For All Patients**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**PLEASE BRING THESE FORMS COMPLETED TO OUR OFFICE ON THE DAY OF YOUR APPOINTMENT**

Thank You!

(519) 641-5995

1290 Byron Baseline Rd., London, ON N6K 2E3