Dr. Scott Kay, B.Sc., D.C.
Dr. Jeff Harris, B.Sc., D.C.
Dr. Dan Kay, B.A., D.C.

First Name ________________________________ Initial _______ Last Name ___________________________

Address ____ Apartment ________ Unit # _________

City ____________________________________ Province ____________________ Postal Code ____________

Who Referred You To Our Clinic? ____

Date of Birth (dd/mm/yyyy) ____ Male _______ Female ________

Phone: Home ________________________ Work _______________________ Cell ______________________

Employer ____

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 as specific as you can with your answers.

THE BEGINNING YEARS OF LIFE (Birth to Age 18)	**YES**	**NO**	**EXPLAIN/COMMENTS:**
Did you have any childhood illnesses?	☐	☐	______________
Did you play youth sports?	☐	☐	______________
Did you have any surgeries?	☐	☐	______________
Did you take/use any drugs?	☐	☐	______________
Have you fallen/jumped from a height over three feet? (crib/bunk bed/trees)	☐	☐	______________
Were you involved in any car accidents as a child?	☐	☐	______________
Was there any prolonged use of medicine, such as antibiotics or an inhaler?	☐	☐	______________
Did you suffer any other traumas? (physical or emotional)	☐	☐	______________
Were you vaccinated?	☐	☐	______________
Were you under regular chiropractic care as a child?	☐	☐	______________

ADULT (Age 18 to Present)	**YES**	**NO**	**EXPLAIN/COMMENTS:**
Do/did you smoke?	☐	☐	______________
Do/did you drink alcohol?	☐	☐	______________
Have you been in any accidents?	☐	☐	______________
Do/did you play any adult sports?	☐	☐	______________
Do/did you participate in extreme sports?	☐	☐	______________

On a scale from 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? ____

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Current Health Condition

People who have 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:
____

Other doctors seen for this condition? ☐ Yes ☐ No Who? ______________________
Type of Treatment: ______________________ Results: ______________________
When did this condition begin? ______________ Has the condition occurred before? ☐ Yes ☐ No
Is the condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other: ______________
Date of Accident: ______________________ Time of Accident: ______________________
What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Dampness ☐ Other: ______________
What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: ______________________
Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better
Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning
☐ Constant ☐ Intermittent
Do you feel your pain radiate down your arms or your legs? ☐ Yes ☐ No ______________
Please describe how it feels when this problem is at its worse: ______________________
____

Place an X on the grade to indicate the severity of your pain:
LEAST 1 2 3 4 5 6 7 8 9 10 *WORST*

Compare this problem at its worst and a time when you feel great. How does this problem interfere with:
Your ability to work? ______________________
Your ability to enjoy your family or your social time? ______________________
Your ability to enjoy your hobbies or sports? ______________________
At its worst, how old does this problem make you feel? ______________________
If you don't get the problem corrected, do you think it will get worse over the next 5 years? ☐ Yes ☐ No
Drugs you take now: ☐ Nerve Pills ☐ Painkillers/Muscle Relaxers ☐ Blood Pressure Medicine
☐ Insulin ☐ Other: ______________________
Do you suffer from any other condition than the one you are now consulting us for? ______________
On a scale of 1 to 10, 10 being the highest, rate your commitment to correcting this problem: ______________
____
Have you had X-rays taken in the last six months? ☐ Yes ☐ No If yes, where? ______________

Past Health History

Major Surgery/Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones ☐ Other: ______________________
Previous: Childhood Traumas ☐ ______________ Sports Injuries ☐ ______________
Motor Vehicle Accidents ☐ ______________ Work Injuries ☐ ______________
Hospitalization (other than above): ______________________

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Family Health History

Name of Family Physician:____

I authorize my treating health professional to collect, use and disclose to my family practitioner, any information relating to my health condition and treatment received as a result of my present condition. Please initial for authorization. __________________

Please indicate any health issues that are present in your family:

Parents: ____

Siblings: ____

Does any member of your family suffer from the same condition? ☐ No ☐ Yes Whom? ______________

Have your children ever had a spinal check-up? ☐ No ☐ Yes ☐ If yes, where and when? ____________

____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of chiropractic care.
Check any of the following you have had in the past six months:

Nervous System
- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Stress

Musculo-Skeletal
- ☐ Low Back Pain
- ☐ Gas/Bloating After Meals
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Black/Bloody Stool
- ☐ Arm Pain
- ☐ Colitis
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

General
- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

C-V-R
- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Gastro-Intestinal
- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

Male / Female
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

Genito-Urinary
- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discolored Urine

Do you suffer from any of the following?:

- ❑ Heart condition / Angina
- ❑ High Blood Pressure
- ❑ Prostate Condition
- ❑ Cancer
- ❑ Arthritis
- ❑ Tendonitis / Bursitis
- ❑ Spinal Disc Problems
- ❑ Weak Immune System
- ❑ Endometriosis
- ❑ Hormonal imbalances
- ❑ PMS
- ❑ Uterine Fibroids
- ❑ Intestinal tract disorder
- ❑ Indigestion
- ❑ Bloating after meals
- ❑ Eczema / Psoriasis

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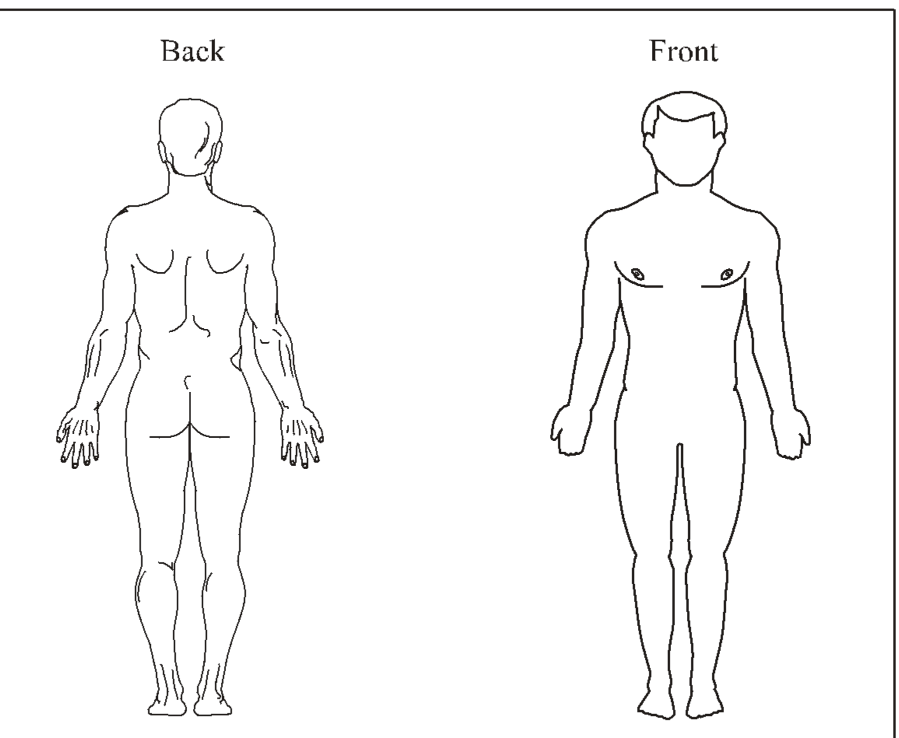
Location of Pain:

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



Why Chiropractic Care?

People go to a Chiropractor for a variety of reasons. Some go for symptomatic relief of a condition (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with chiropractic care (Preventative Care). These are the three phases of care. Your doctor will weigh your needs and desires when recommending your schedule of care. However, the prepared recommendation is an incorporation of all three phases. How long you choose to benefit from Chiropractic is always up to you.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- ☐ Preventative/Wellness Care – Life Enhancement and Wellness Care
- ☐ Corrective Care – Removing Cause and Remodeling Soft Tissue
- ☐ Relief Care – Band-Aid Care Only
- ☐ Check here if you want the doctor to select the type of care appropriate for your condition.

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