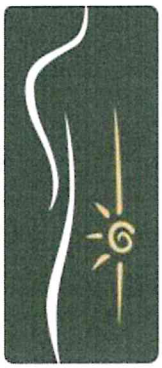
**British Columbia Back Clinic**
15150 Hwy 10, Suite 102
Surrey, BC V3S 1B8



**Phone: (778) 574-4999**
**Fax: (778) 574-4909**

## *Personal Health Profile*

**Name:** _____ **Today's Date (mm/dd/yyyy):** __/ __/ ___
**Address:** _____ **City:** _____ **Prov:** _____ **Postal Code:** _____
**Phone Number: Home:** (__) _____ **Work:** (__) _____ **Cell:** (__) _____
**Birth Date (mm/dd/yyyy)** ___/____/_____ **Gender: Male** ☐ **Female** ☐
**Email:** _____ **BC Care Card #** _____

**I prefer to be contacted at:**
☐ Home
☐ Work
☐ Cell
☐ Email

**Occupation:** _____

**EMERGENCY CONTACT:** Name: _____ Relationship: _____
Home Phone: _____ Cell Phone: _____

**How did you find our clinic? Check one:**
☐ Friend/Co-worker Name: _____
☐ Internet
☐ Yellow Pages
☐ Clinic Signage
☐ Radio
☐ Other: _____

**ACCIDENT INFORMATION**
Is your condition due to an accident? ☐ Yes ☐ No
To whom have you reported the accident? ☐ ICBC ☐ WorkSafe BC ☐ Employer ☐ Other: _____

**YOUR HEALTH PROFILE**
Have you received chiropractic spinal adjustments by a Doctor of Chiropractic ☐ Yes ☐ No
If yes, what was the Doctor's name and when was your last visit? _____
How long were you receiving chiropractic adjustments?_____
How was your overall chiropractic experience? _____

**YOUR WELLNESS GOALS**

What are your health goals?

_____

What are your health objectives in consulting with BC Back Clinic? _____

_____

What are your objectives regarding your health once you feel your symptom/concern is dealt with?

_____

**Other stressors throughout our life impact our body's ability to adapt and function. Please take a moment to consider the impact of past or current stresses.**

**PHYSICAL STRESS**

Have you experienced any of the following? If so, please indicate if this happened in the past or is a current or ongoing concern **AND** indicate the severity of the concern.

| | |
|---|---|
| Birth Trauma | ☐ Past ☐ Present / ☐ Mild ☐ Significant Explain: _____ |
| Falls | ☐ Past ☐ Present / ☐ Mild ☐ Significant Explain: _____ |
| Vehicle Accidents | ☐ Past ☐ Present /☐ Mild ☐ Significant Explain: _____ |
| Work Injuries | ☐ Past ☐ Present /☐ Mild ☐ Significant Explain: _____ |
| Sports | ☐ Past ☐ Present /☐ Mild ☐ Significant Explain: _____ |

**CHEMICAL STRESS**

Are you CURRENTLTY taking any medications? If yes, please specify the name and purpose _____

_____

Do you smoke or have you in the past? Yes ☐ No ☐

**EMOTIONAL STRESS**

How would you grade your emotional/mental health? Please circle.

**Excellent** **Good** **Fair** **Getting Better** **Getting Worse**

Please rate how each of the following 5 categories applies to you:

**3 = Very important to me 2= Important to me 1 = Not so important to me 0 = Does not apply**

a) ____ Improvement of my physical symptoms
b) ____ Improvement of my ability to react or respond to stress
c) ____ Improvement in enjoyment of life and the ability to make constructive decisions
d) ____ Overall improved quality of life

Is there anything else that may help us to understand you, your history, or your specific needs, which have not been discussed on this health profile? _____

_____

_____

## Please Indicate With an X All Symptoms That You Have Experienced Within the Last 6 Months:

**HEAD:**
- ☐ Headache
  - ☐ Sinus
  - ☐ Entire Head
  - ☐ Back of Head
  - ☐ Forehead
  - ☐ Temples
  - ☐ Migraine
- ☐ Head feels Heavy
- ☐ Loss of Memory
- ☐ Fainting
- ☐ Light bothers Eyes
- ☐ Blurred Vision
- ☐ Double Vision
- ☐ Loss of Vision
- ☐ Loss of Balance
- ☐ Loss of Taste
- ☐ Loss of Hearing
- ☐ Dizziness
- ☐ Pain in Ears
- ☐ Ringing or Noise in Ears

**NECK:**
- ☐ Pain in Neck
- ☐ Neck Pain with Movement
  - ☐ Forward
  - ☐ Backward
  - ☐ Turning (L or R)
  - ☐ Bending (L or R)
- ☐ Pinched Nerve in Neck
- ☐ Neck Feels Out of Place
- ☐ Muscle Spasms in Neck
- ☐ Grinding Sounds in Neck
- ☐ Popping Sounds in Neck
- ☐ Arthritis in Neck

**SHOULDERS:**
- ☐ Pain in Joint (L or R)
- ☐ Pain Across Shoulders
- ☐ Bursitis (L or R)
- ☐ Arthritis
- ☐ Can't Raise Arm
  - ☐ Above Shoulder Level
  - ☐ Overhead
- ☐ Tension in Shoulders
- ☐ Pinched Nerve in Shoulder (L or R)
- ☐ Muscle Spasm in Shoulder

**ARMS AND HANDS:**
- ☐ Pain in Arm
- ☐ Tennis Elbow
- ☐ Pain in Hands/Fingers (L or R)
- ☐ Pins & Needles Sensation (L or R)
- ☐ Numbness (L or R)
- ☐ Hands Cold
- ☐ Loss of Grip
- ☐ Sore/Swollen Joints in Fingers
- ☐ Arthritis in Fingers

**MIDBACK:**
- ☐ Mid-Back Pain
- ☐ Pain Between Shoulder Blades
- ☐ Sharp Stabbing
- ☐ Dull Ache
- ☐ Muscle spasms
- ☐ Pain in Kidney Area

**CHEST:**
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Rib Pain
- ☐ Breast Pain
- ☐ Irregular Heartbeat

**ABDOMEN:**
- ☐ Nervous Stomach
- ☐ Food I Can't Eat
- ☐ Nausea
- ☐ Gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids

**HIPS & LEGS:**
- ☐ Pain in Buttocks (L or R)
- ☐ Pain in Hip Joint (L or R)
- ☐ Pain Down Leg (L or R)
- ☐ Knee Pain (L or R)
  - ☐ Outside
  - ☐ Inside
- ☐ Leg Cramps
- ☐ Feet Cramps
- ☐ Pins & Needles in Legs
- ☐ Numbness in Legs/Feet
- ☐ Swelling in Legs/Feet

**LOW BACK:**
- ☐ Lower Back Pain (L or R)
  - ☐ Upper Lumbar
  - ☐ Lower Lumbar

Low Back Pain is Worse When:
- ☐ Working
- ☐ Lifting
- ☐ Standing
- ☐ Sitting
- ☐ Bending
- ☐ Coughing
- ☐ Lying Down
- ☐ Walking

Pain is Relieved When:

_____

- ☐ Slipped Disc
- ☐ Low Back Feels Out of Place
- ☐ Muscle Spasm
- ☐ Arthritis

**GENERAL:**
- ☐ Nervousness
- ☐ Irritable
- ☐ Depressed
- ☐ Fatigue
- ☐ Run-down Feeling
- ☐ Normal Sleep Hrs _____
- ☐ Loss of Sleep
- ☐ Loss of Weight Lbs _____
- ☐ Weight Gain Lbs _____
- ☐ Coffee _____ Cups /Day
- ☐ Tea _____ Cups/Day
- ☐ Cigarettes _____ Pks/Day
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Numbness
- ☐ Tingling
- ☐ Other _____