FOR OFFICE USE ONLY:

ROF	MON	TUES	WED	THURS
GUEST				

- ☐ Dr. Justine Blainey-Broker, B.Sc., D.C.
- ☐ Dr. Blake Broker, B.Sc, D.C.
- ☐ Dr. Steve Gillis, BPE, ART, D.C.
- ☐ Dr. Stephanie Johston B.S.c., D.C.

220 Wexford Road, Unit 2 Brampton, ON L6Z 4N7 (905) 840-WELL

Confidential Patient Case History

		DI
CE		
SUB		
X-RAY C/SP		
X-RAY T/SP		
X-RAY L/SP		
X-RAY OTHER		
GAIT		
TOTAL		

Name:_____ Age: _____ Today's Date: _____

Address: _____
Residence and Mailing City Province/State Postal Code/Zip

Home Telephone Number: _____

Work Telephone Number: _____ Cell Phone Number:_____

Email: _____ Birth date: _____ Male: __ Female:__

Occupation: _____ Employed by: _____

Single: ___ Married: ___ Divorced: ____ Widowed:____ Partner's Name: _____

Number of children: _____ Names of children:

_____

Have you had previous chiropractic care? (circle one) Yes No Chiropractor's name: _____

Medical Doctor's name and phone number: _____

Who may we thank for referring you to our office?_____

Reason for Consulting our Office:

_____

Your Health Profile

Why This Form Is Important

On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (To Age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	YES	NO	UNSURE
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take/use any drugs?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree)	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	YES	NO	UNSURE
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?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

Adult Years (Age 18 to present)

	YES	NO
Do/did you smoke?	☐	☐
Do/did you drink alcohol?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐

	YES	NO
Do/did you play any adult sports?	☐	☐
Do/did you participate in extreme sports?	☐	☐

On a scale of 1-10 describe your stress level:
(1 = none, 10 = extreme)

Occupational: ____ Personal: _____

On a scale of POOR, GOOD, or EXCELLENT, describe your:

Diet: _____ Exercise:_____ Sleep: _____ General Health:_____

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Wellness Check up: Circle: Yes No

Specific Concerns:_____

_____

If you are experiencing pain, is it:

☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing ☐ Radiating

Since the problem started, it is: ☐ About the Same ☐ Getting Better ☐ Getting Worse

What makes it worse? _____

How frequent is the complaint? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night Only

How long does it last? ☐ All day ☐ A Few Hours ☐ Minutes

Is there anything you can do to relieve the problem? ☐ Yes ☐ No If yes describe: _____

It Interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

0 1 2 3 4 5 6 7 8 9 10

Please mark an X on the line above to indicate your problem level

Please check (√) all symptoms you have ever had, even if they do not seem related to your current problem.

Headaches	Pins & Needles in Legs	Fainting	Neck Pain
☐ Pins & Needles in Arms	☐ Pins & Needles in Legs	☐ Fainting	☐ Neck Pain
☐ Dizziness	☐ Loss of Smell	☐ Back Pain	☐ Loss of Balance
☐ Numbness in Fingers	☐ Buzzing in Ears	☐ Ringing in Ears	☐ Nervousness
☐ Fatigue	☐ Numbness in Toes	☐ Loss of Taste	☐ Upset Stomach
☐ Sleeping Problems	☐ Depression	☐ Irritability	☐ Tension
☐ Diarrhea	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Cold Sweats	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Mood Swings	☐ Sensitive Eyes	☐ Problem Urinating	☐ Heartburn
☐	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

Please note any major illnesses you have had: ☐ Heart disease ☐ Cancer ☐ Diabetes Other: _____

_____

Please list any major accidents or surgeries you have had: _____

_____

Please list any medications you are taking:_____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

	NAME(S):	Condition(s):
Children:		
Sister(s):		
Spouse:		
Mother:		
Father:		
Brother(s):		
Others:		

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Stress Test

When in your life did you experience any of the stresses listed below: C (child), T (teenager), A (adult), N (not at all)

I. **PHYSICAL STRESS:**

					Explain
Birth Trauma	C	T	A	N	
Slips/Falls	C	T	A	N	
Sports Injuries	C	T	A	N	
Poor Posture	C	T	A	N	
Extensive Computer Work	C	T	A	N	
Carrying Heavy Objects	C	T	A	N	
Repetitive Lifting/Bending	C	T	A	N	
Continuous Sitting/Standing	C	T	A	N	
Bone Fracture/Surgery	C	T	A	N	
Driving For Many Hours	C	T	A	N	
Car Accidents (How many? ____)	C	T	A	N	
Physical Abuse	C	T	A	N	
Work Injuries (How many? ____)	C	T	A	N	
Sleeping Position/Stomach	C	T	A	N	

II. **CHEMICAL STRESS:**

					Explain
Smoker – Amount? _____	C	T	A	N	
Second-Hand Smoke	C	T	A	N	
Poor Diet	C	T	A	N	
Caffeine – Amount? _____	C	T	A	N	
Excessive Sugar	C	T	A	N	
Artificial Sweeteners	C	T	A	N	
Prescription Drugs	C	T	A	N	
Over-The-Counter Drugs (Tylenol, Advil, etc.)	C	T	A	N	
Environmental Pollution (Air, Water, etc.)	C	T	A	N	

III. **EMOTIONAL STRESS:**

					Explain
Relationships	C	T	A	N	
Career	C	T	A	N	
Children	C	T	A	N	
Money	C	T	A	N	
Fast-Paced Life	C	T	A	N	
Internalized Feelings	C	T	A	N	
Perfectionist	C	T	A	N	
Procrastinator	C	T	A	N	
Sickness or Loss of a Loved One	C	T	A	N	
Quick Temper	C	T	A	N	
Verbal Abuse	C	T	A	N	

IV. WHICH DO YOU FEEL IS YOUR PRIMARY STRESS? ☐ PHYSICAL ☐ CHEMICAL OR ☐ EMOTIONAL?

Explain:_____

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NOTE TO PATIENT: We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you. If you have any questions, please ask.

I, _____

- have read the below statement and consent to examination and if appropriate, treatment:

Physicians, Chiropractors, Osteopaths, and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or strokes like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays, have been performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions and other conditions.
I understand all accounts are payable when service is rendered.

- Consent to all encompassing chiropractic treatments knowing the Doctor (s) will discuss ahead of time them with me. (Example: Orthotics, change of techniques etc.)

- Consent to seeing another JBWC Doctor if/when needed. (Example: Time restrictions, scheduling, acute condition needing help and my primary Doctor is away etc.)

- I understand that to provide me with health goods and services, the Justine Blainey Wellness Centre will collect some personal information about me (e.g., home telephone number, address).

I understand that the Justine Blainey Wellness Centre has a Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information.

I understand that I may receive the following: newsletters, Thank you cards, Birthday cards, phone calls, health packages etc. that may be of interest to me.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to the Justine Blainey Wellness Centre collecting, using, and disclosing personal information about me as set above and in the Justine Blainey Wellness Centre's Privacy Policy.

I hereby authorize the release of my medical/chiropractic records or copies of the same to such parties that the doctor may deem necessary as it relates to my case, and do hereby hold harmless anyone from such actions.

Signature of Patient: _____

Witness: _____

Date: _____