ActiveLiving

Name _____ **Phone (home)** _____

Birthdate _____(month / day / year) (cell) _____

Address _____ (work) _____

_____ **Email** _____

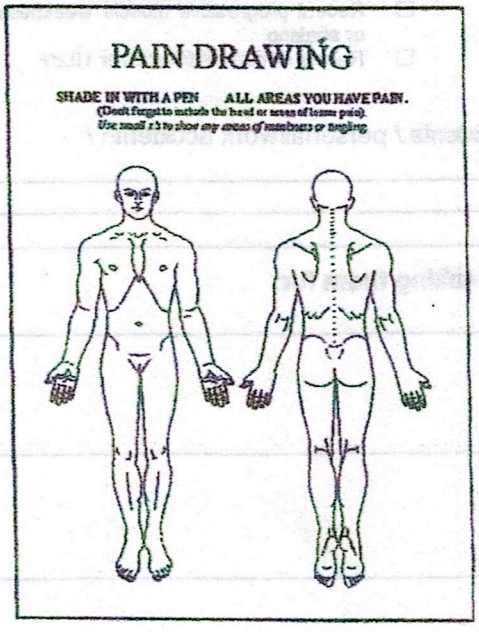
Postal Code _____ **Occupation** _____

How did you hear about our clinic? ▫Friend:_____

▫Yellow Pages ▫Sign ▫Website ▫Other:_____

Do you currently wear orthotics? ▫Yes ▫No

CURRENT CONDITION:



Please describe your current condition & symptoms:_____

_____

How long have you had this condition/symptom?_____

Have you had this condition before? YES NO **When?**:_____

What makes it better (positions/activities/movements)?_____

What makes it worse(positions/activities/movements)?_____

What % of each day does it bother you? (Circle one)

0% 25%(Intermittent) 50%(Occasional) 75%(Frequent) 100%(Constant)

Does this affect you at:

Work Play/Activities/Exercise Sleep Romance/Love life

Please mark on the line, the pain level that most accurately represents your pain for each body area:

	0	1	2	3	4	5	6	7	8	9	10
Average pain:	No pain										Unbearable

GOALS FOR CARE: Check all that apply

- ▫ RELIEF I want to feel better for the least amount of my time and money.
- ▫ CORRECTION I want to stabilize and retrain the muscles and ligaments of my spine and skeletal system.
- ▫ MAINTENANCE I want to preserve the progress I've made
- ▫ PREVENTION I want to avoid losing my health
- ▫ WELLNESS I want to be all that I can be, high quality performance, sleep, energy, immune system, maximum brain power and more.

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PERSONAL HEALTH HISTORY - The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

GENERAL CURRENT CONDITIONS

- ☐ **Recent accident** such as a fall, whiplash, or blow to the head
- ☐ Spinal/back/neck problems
- ☐ Muscle spasms
- ☐ Restricted movement
- ☐ Numbness or tingling of hands or feet or radiating pain
- ☐ Headaches or Migraines
- ☐ Sinus problems
- ☐ Nausea
- ☐ Depression
- ☐ Anxiety or difficulty with stress
- ☐ Dizziness or vertigo
- ☐ Vision problem
- ☐ Hearing problem
- ☐ Sleeping trouble
- ☐ Asthma or breathing problem
- ☐ Digestive trouble
- ☐ Heartburn/Acid Reflux
- ☐ Menstrual problems
- ☐ Jaw or mouth problem
- ☐ Arm, shoulder, elbow or hand problem
- ☐ Leg, hip, knee or foot problem

DIAGNOSED CONDTIONS

- ☐ Born with bone or joint disorder
- ☐ Osteoporosis
- ☐ Degenerative arthritis/Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Compression fracture
- ☐ Heart attack or heart disorder
- ☐ History of stroke or aneurysm
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Lupus
- ☐ Ankylosing spondylitis
- ☐ Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
- ☐ 3 or more months of steroid medications or intravenous drugs (past or present)
- ☐ Tuberculosis
- ☐ Hepatitis B or HIV infection
- ☐ Multiple sclerosis
- ☐ Thyroid or hormone disorder
- ☐ High blood pressure
- ☐ Convulsions/epilepsy
- ☐ OTHER:

SPECIFIC PAIN IN THE BODY

- ☐ Pain or electric shocks in arms or legs when moving neck
- ☐ Leg pain worse with exercise
- ☐ Numbness of inner thighs
- ☐ Back pain with urinary problems
- ☐ Severe pain that interrupts sleep
- ☐ Constant pain that doesn't improve by changing positions or by lying down

SPECIFIC CURRENT CONDITIONS

- ☐ Poor balance
- ☐ Loss of bowel or bladder control
- ☐ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ☐ Memory loss after injury
- ☐ Recent, unexplained weight loss
- ☐ Recent progressive muscle weakness or shaking
- ☐ Recent or current fever over 102°F

Describe any **surgeries** / hospitalizations / motor vehicle accidents / sporting accidents / personal/work accidents / fractures / dislocations / & / or illnesses you've had and the **dates**:_____

_____

_____

Please list any Medications you presently take AND what condition you are taking them for:

_____

Current supplements and **Why** you are taking them:

_____

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)

_____

YOUR LIFESTYLE

Height_____ **Weight**_____Has your **weight** changed recently? Gained____ Lost___ No change ___

How many **hours of sleep**_____

Sleep position: Side Front Back

Quality of sleep: Poor Moderate Excellent

Do you drink **Alcohol**?_____drinks/day

Grind your teeth/clench? No Yes

How many **hours do you sit?** _____/day

Diet: Poor Moderate Excellent

Would you like advice? No Yes

Do you **Smoke:** No Yes _____cigs/day

Exercise: No Yes, _____/week

Gym/Cardio Weights Core

Yoga Pilates Bootcamp Crossfit

Swimming Biking Running Other

For Women: Are you pregnant? ☐Yes ☐No Date of Last Period_____

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TREATMENT HISTORY:

	Name/Location	Date of last visit	Years of Care or # of treatments	Result of Treatment	Comments
Massage Therapy				Excellent Good Fair Poor	
Chiropractor				Excellent Good Fair Poor	
Physiotherapy				Excellent Good Fair Poor	
Naturopath				Excellent Good Fair Poor	
Acupuncture				Excellent Good Fair Poor	
Other (specify)				Excellent Good Fair Poor	

Other therapy / treatment: (past or present, does not have to be related to this visit)

Your **Medical Practitioner's** Name:_____ Phone:_____
Date last seen _____ Reason for visit _____ Recent medical testing: Xrays___ Blood test ____ Other____
Permission to contact your medical doctor (Signature) _____

FAMILY HISTORY

Please state **who** has/had condition (eg. maternal grandma), **how old** they were **when diagnosed**, & **what type** (eg. Lung CA). Have they passed away?

Cancer (Type) _____Diabetes_____Stroke_____
Heart disease _____Kidney disease _____Mental illness_____Seizures_____
Autoimmune disorder_____Other:_____

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated Practitioners to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated Practitioners to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: **Date:**