HEALING HANDS FAMILY WELLNESS

46 ELMA STREET, OKOTOKS, AB T1S 1J7
PHONE :(403) 938-4025

Application for Care

Today's Date: _____

Our office purpose is to restore and maintain the optimum health of our patients through natural chiropractic methods. Please complete this confidential health questionnaire fully and accurately. The more we know about your overall picture of health, the better we will be able to help you.

PATIENT DEMOGRAPHICS

Name: _____ Birth Date (MM/DD/YY) _____-_____-_____ Age: _____ ☐ Male ☐ Female

Address: _____ City: _____ Prov: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Who may we thank for referring you to this office? _____ (or ☐ Location ☐ Phonebook ☐ Google ☐ Other _____)

Alberta Health Care Number: _____

Your Occupation: _____ Your Employer: _____

Marital Status (circle one) Single / Married / Common-law / Widow Spouse/Partner's Name: _____

Spouse/Partner's Occupation: _____ How many children? _____ Their Ages? _____

Name of Emergency Contact: _____ Phone #: _____ Relationship: _____

COMPLAINT HISTORY

Please identify the complaints that have brought you to our office: Primary: _____

Secondary: _____ Third: _____ Fourth: _____

On the scale of **0** to **10**, with **10** being the worst pain, rate your above complaints from 0 to 10.

		Circle when it is at it's worst	Circle how long it lasts	When did each appear?
Primary or chief complaint:	1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10	AM / MID-DAY / PM	CONSTANT | OFF/ON DAILY | COMES & GOES WEEKLY	_____
Secondary complaint:	1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10	AM / MID-DAY / PM	CONSTANT | OFF/ON DAILY | COMES & GOES WEEKLY	_____
Third complaint:	1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10	AM / MID-DAY / PM	CONSTANT | OFF/ON DAILY | COMES & GOES WEEKLY	_____
Fourth complaint:	1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10	AM / MID-DAY / PM	CONSTANT | OFF/ON DAILY | COMES & GOES WEEKLY	_____

What worsens your symptoms? _____ What relieves your symptoms? _____
Have you lost any days from work due to this condition? ☐ YES ☐ NO Is your condition interfering with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Relationship ☐ Other
Is your condition getting progressively worse? ☐ YES ☐ NO ☐ CONSTANT ☐ COMES & GOES How long has it been since you really felt good? _____
Is your problem the result of any type of accident? ☐ YES ☐ NO Is it related to a Worker's Compensation Injury? ☐ YES ☐ NO
Are you presently taking medication or pain killers? ☐ YES ☐ NO If yes, list: _____
Have you had a X-ray taken in the last 2 years? ☐ YES ☐ NO If yes where: _____

How did the injury happen? _____ Have the condition(s) ever been treated by anyone in the past? ☐ YES ☐ NO

If **YES**, when? _____ By whom? _____ How long were you under care? _____

What were the results? _____ Name of previous Chiropractor? _____

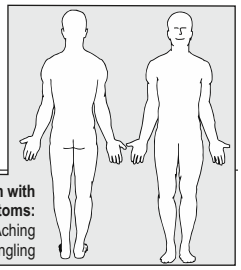
How was your previous experience chiropractic experience? _____

SUPPORTING HEALTH HISTORY

Do you wear: ☐ HEEL LIFTS ☐ SOLE LIFTS ☐ INNER SOLES ☐ ARCH SUPPORTS ☐ LUMBER SUPPORT BELT
Do you now take vitamins and minerals? ☐ YES ☐ NO. If yes, list: _____
Do you smoke? ☐ YES ☐ NO ____ PACKS/DAY Do you drink coffee? ☐ YES ☐ NO ____ CUPS/DAY
Do you consume alcohol? ☐ YES ☐ NO ____ DRINKS/ ☐ DAY ☐ WEEK Do you use recreational drugs? ☐ YES ☐ NO
Do you do aerobic exercise regularly? ☐ YES ☐ NO If YES, usually ☐ INDOORS ☐ OUTDOORS
Do you sleep soundly? ☐ YES ☐ NO Do you wake rested? ☐ YES ☐ NO Do you take sleeping pills? ☐ YES ☐ NO
How is your appetite? ☐ POOR ☐ FAIR ☐ MEDIUM ☐ GOOD ☐ EXCELLENT
How is your diet? ☐ POOR ☐ FAIR ☐ MEDIUM ☐ GOOD ☐ EXCELLENT
Do you regularly eat? Breakfast ☐ YES ☐ NO | Lunch ☐ YES ☐ NO | Dinner ☐ YES ☐ NO | Bedtime Snack ☐ YES ☐ NO

List any accidents you've had and when:: _____

List any surgeries you've had and when: _____



PLEASE MARK the areas on the Diagram with the following letters to describe your symptoms:
R = Radiating **B** = Burning **D** = Dull **A** = Aching
N = Numbness **S** = Sharp/Stabbing **T** = Tingling

What is the reason for coming to our office? ☐ PREVENTION ☐ MAINTENANCE
☐ SPECIFIC SYMPTOM ☐ SPOUSE ☐ OTHER _____

What is the goal that you would like to achieve at this office by having your optimum health restored? (ie. playing with grandchildren, sleep, pain-free, etc.):

Goal: _____

Please check the appropriate box for any of the following symptoms which you have now or have had in the past.

c=constant f=frequent o=occasional p=previously

NEUROLOGICAL

c	f	o	p	
☐	☐	☐	☐	allergy
☐	☐	☐	☐	chills
☐	☐	☐	☐	dizziness
☐	☐	☐	☐	neuralgia
☐	☐	☐	☐	loss of weight
☐	☐	☐	☐	fainting
☐	☐	☐	☐	slurred speech
☐	☐	☐	☐	loss of consciousness
☐	☐	☐	☐	sudden collapse
☐	☐	☐	☐	numbness
☐	☐	☐	☐	tremors
☐	☐	☐	☐	headaches
☐	☐	☐	☐	loss of sleep
☐	☐	☐	☐	nervousness
☐	☐	☐	☐	depression
☐	☐	☐	☐	sweats
☐	☐	☐	☐	sciatica

PAIN OR NUMBNESS

☐	☐	☐	☐	shoulders
☐	☐	☐	☐	hips
☐	☐	☐	☐	ankles
☐	☐	☐	☐	fingers
☐	☐	☐	☐	arms
☐	☐	☐	☐	legs
☐	☐	☐	☐	feet
☐	☐	☐	☐	toes
☐	☐	☐	☐	hands
☐	☐	☐	☐	knees
☐	☐	☐	☐	face
☐	☐	☐	☐	back

MUSCLE & JOINT

☐	☐	☐	☐	arthritis
☐	☐	☐	☐	neck pain
☐	☐	☐	☐	neck stiffness
☐	☐	☐	☐	painful tailbone
☐	☐	☐	☐	neuralgia
☐	☐	☐	☐	loss of weight
☐	☐	☐	☐	bursitis
☐	☐	☐	☐	pain between shoulders
☐	☐	☐	☐	muscle cramping
☐	☐	☐	☐	swollen joints
☐	☐	☐	☐	numbness
☐	☐	☐	☐	tremors
☐	☐	☐	☐	foot trouble
☐	☐	☐	☐	low back pain
☐	☐	☐	☐	bone spurs

EYES, EARS, NOSE, THROAT

c	f	o	p	
☐	☐	☐	☐	colds
☐	☐	☐	☐	ringing in the ears
☐	☐	☐	☐	deafness
☐	☐	☐	☐	ear aches
☐	☐	☐	☐	ear discharges
☐	☐	☐	☐	ear noises
☐	☐	☐	☐	gum trouble
☐	☐	☐	☐	dental decay
☐	☐	☐	☐	loss of sleep
☐	☐	☐	☐	nasal obstruction
☐	☐	☐	☐	hay fever
☐	☐	☐	☐	sinus infections
☐	☐	☐	☐	nosebleeds
☐	☐	☐	☐	enlarged glands
☐	☐	☐	☐	enlarged thyroid
☐	☐	☐	☐	difficulty swallowing
☐	☐	☐	☐	sore throat
☐	☐	☐	☐	hoarseness
☐	☐	☐	☐	tonsillitis
☐	☐	☐	☐	eye pain
☐	☐	☐	☐	double vision
☐	☐	☐	☐	blurred vision
☐	☐	☐	☐	far sighted
☐	☐	☐	☐	near sighted
☐	☐	☐	☐	temporary loss of vision
☐	☐	☐	☐	crossed eyes
☐	☐	☐	☐	ear infections

GASTRO INTESTINAL

☐	☐	☐	☐	excessive hunger
☐	☐	☐	☐	poor appetite
☐	☐	☐	☐	burping or gas
☐	☐	☐	☐	liver trouble
☐	☐	☐	☐	gall bladder trouble
☐	☐	☐	☐	colitis
☐	☐	☐	☐	constipation
☐	☐	☐	☐	diarrhea
☐	☐	☐	☐	gallstones
☐	☐	☐	☐	difficult digestion
☐	☐	☐	☐	nausea
☐	☐	☐	☐	stomach pain
☐	☐	☐	☐	hiatal hernia
☐	☐	☐	☐	inguinal hernia
☐	☐	☐	☐	intestinal worms
☐	☐	☐	☐	hemorrhoids
☐	☐	☐	☐	vomiting / vomiting blood
☐	☐	☐	☐	distention of abdomen

RESPIRATORY

c	f	o	p	
☐	☐	☐	☐	chest pain
☐	☐	☐	☐	chronic cough
☐	☐	☐	☐	difficulty breathing
☐	☐	☐	☐	sharp chest pains
☐	☐	☐	☐	throat phlegm
☐	☐	☐	☐	recurring bronchitis
☐	☐	☐	☐	wheezing
☐	☐	☐	☐	spitting blood
☐	☐	☐	☐	asthma

SKIN

c	f	o	p	
☐	☐	☐	☐	boils
☐	☐	☐	☐	bruise easily
☐	☐	☐	☐	dryness
☐	☐	☐	☐	hives or allergy
☐	☐	☐	☐	itching
☐	☐	☐	☐	skin rash
☐	☐	☐	☐	Are you alert test!
☐	☐	☐	☐	If so, check all 4 boxes

GENITO-URINARY

☐	☐	☐	☐	diabetes
☐	☐	☐	☐	blood in urine
☐	☐	☐	☐	puss in urine
☐	☐	☐	☐	bed-wetting
☐	☐	☐	☐	frequent urination
☐	☐	☐	☐	lack control urination
☐	☐	☐	☐	kidney infection
☐	☐	☐	☐	painful urination
☐	☐	☐	☐	prostate trouble
☐	☐	☐	☐	smelly urine

CARDIO-VASCULAR

☐	☐	☐	☐	rapid heart beat
☐	☐	☐	☐	slow heart beat
☐	☐	☐	☐	pain over heart
☐	☐	☐	☐	high blood pressure
☐	☐	☐	☐	low blood pressure
☐	☐	☐	☐	poor circulation
☐	☐	☐	☐	hardening of the arteries
☐	☐	☐	☐	swelling ankles
☐	☐	☐	☐	varicose veins

FOR WOMEN ONLY

☐	☐	☐	☐	cramps
☐	☐	☐	☐	heavy flow
☐	☐	☐	☐	light flow
☐	☐	☐	☐	irregular cycle
☐	☐	☐	☐	painful cycle
☐	☐	☐	☐	abnormal discharge
☐	☐	☐	☐	sore breasts

Menopausal ☐ Yes ☐ No

Last menstral date _____

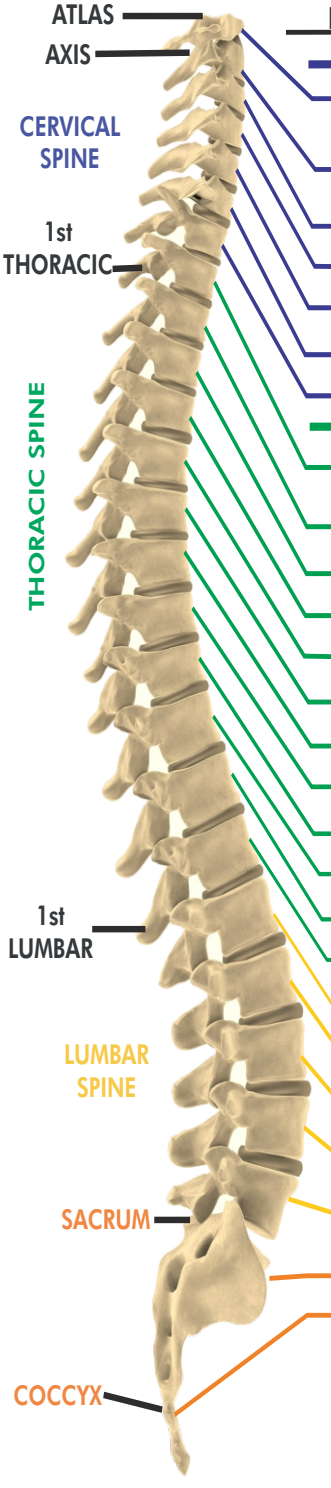
Pregnant ☐ Yes ☐ No

Due Date _____

SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

"The nervous system controls and coordinates all organs and structures of the human body." (*Gray's Anatomy, 29th Ed., page 4*). Misalignments of spinal vertebrae and discs may cause irritation to the nervous system which 1) affects the structures, organs, and functions listed under "areas." 2) creates the corresponding conditions or symptoms that are listed under "Possible Effects".

Please help us help you by placing a check mark in the appropriate box under the "Possible Effects" column to indicate your symptoms.



Vertebral Level	Areas		Possible Effects
C1	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	NECK-REGION	☐ headaches ☐ nervousness ☐ insomnia ☐ head colds ☐ high blood pressure ☐ migraines ☐ nervous breakdowns ☐ amnesia ☐ chronic tiredness ☐ dizziness
C2	Eyes, optic nerves, auditory nerves, sinuses, mastoid bones, tongue, forehead.		☐ sinus trouble ☐ allergies ☐ pain around the eyes ☐ earache ☐ fainting spells ☐ certain cases of blindness ☐ crossed eyes ☐ deafness
C3	Cheeks, outer ear, face bones, teeth, tri-facial nerve.		☐ neurualgia ☐ neuritis ☐ acne or pimples ☐ eczema
C4	Nose, lips, mouth, eustachian tube.		☐ hay fever ☐ runny nose ☐ hearing loss ☐ adenoids
C5	Vocal cords, neck glands, pharynx.		☐ laryngitis ☐ hoarseness ☐ throat conditions such as sore throat or quinsy
C6	Neck muscles, shoulders, tonsils.		☐ stiff neck ☐ pain in upper arm ☐ tonsilitis ☐ chronic cough ☐ croup.
C7	Thyroid gland, bursae in the shoulders, elbows.		☐ bursitis ☐ colds ☐ thyroid conditions
T1	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.	MID-BACK	☐ asthma ☐ cough ☐ difficult breathing ☐ shortness of breath ☐ pain in lower arms and hands
T2	Heart, including its values and covering; coronary arteries.		☐ functional heart conditions and certain chest conditions
T3	Lungs, bronchial tubes, pleura, chest, breast.		☐ bronchitis ☐ pleurisy ☐ pneumonia ☐ congestion ☐ influenza
T4	Gall bladder, common duct.		☐ gall bladder conditions ☐ jaundice ☐ shingles
T5	Liver, solar plexus, circulation (general).		☐ liver conditions ☐ fevers ☐ blood pressure problems ☐ poor circulation ☐ arthritis
T6	Stomach.		☐ stomach troubles, including nervous stomach ☐ indigestion ☐ heartburn ☐ dyspepsia
T7	Pancreas, duodenum.		☐ ulcers ☐ gastritis
T8	Spleen.		☐ lowered resistance
T9	Adrenal and supra-renal glands.		☐ allergies ☐ hives
T10	Kidneys.		☐ kidney troubles ☐ hardening of the arteries ☐ chronic tiredness ☐ nephritis ☐ pyelitis
T11	Kidneys, ureters.		☐ skin conditions such as acne ☐ pimples ☐ eczema ☐ or boils
T12	Small intestines, lymph circulation.		☐ rheumatism ☐ gas pains ☐ certain types of sterility
L1	Large intestines, inguinal rings.	LOW BACK	☐ constipation ☐ colitis ☐ dysentery ☐ diarrhea ☐ some ruptures or hernias
L2	Appendix, abdomen, upper leg.		☐ cramps ☐ difficult breathing ☐ minor varicose veins
L3	Sex organs, uterus, bladder, knees.		☐ bladder troubles ☐ menstrual troubles such as painful or irregular periods ☐ miscarriages ☐ bedwetting ☐ impotency ☐ change of life symptoms ☐ knee pains
L4	Prostate gland, muscles of the lower back, sciatic nerve.		☐ sciatica ☐ lumbago ☐ difficult, painful, or too frequent urination ☐ backaches
L5	Lower legs, ankles, feet.		☐ poor circulation in the legs ☐ swollen ankles ☐ weak ankles and arches ☐ cold feet ☐ weakness in the legs ☐ leg cramps
SACRUM	Hip bones, buttocks.	PELVIS	☐ sacro-iliac conditions ☐ spinal curvatures
COCCYX	Rectum, anus.		☐ hemorroids (piles) ☐ pruritis (itching) ☐ pain at the end of the spine on sitting.

For further explanation of the conditions shown above, and information about those not shown, ask your Doctor of Chiropractic.

HEALING HANDS FAMILY WELLNESS

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PHONE :(403) 938-4025

OPT-IN CONSENT FOR EMAIL

- I would like to communicate by email with Healing Hands Family Wellness.
- I will be responsible for maintaining any information regarding my care that I have saved onto my personal computer.
- I understand that my email authorization and a copy of these email guidelines that I have received will become part of my permanent medical record.
- I agree to follow the guidelines for email communication with Healing Hands Family Wellness and will use email for non-emergency purposes only.
- Emails containing transitory information (routine or short term transactions, and contain little or no information of on-going value, (i.e. confirmation of appointments) will be securely deleted by the Clinic.
- Email correspondence containing clinical or significant information will be entered into my permanent health record by Healing Hands Family Wellness.
- I agree to inform Healing Hands Family Wellness if my email address changes.
- I understand that the Clinic will normally respond to email communications within 1 business day. If I have not heard from the Clinic by this time, I will phone the Clinic.

☐ I agree to receive email reminders from Healing Hands Family Wellness for my appointments. To opt-out of this reminder service, simply notify us by phone at 403-938-4025 or email at healinghandswellness@telus.net.

☐ I agree to receive emails from Healing Hands Family Wellness regarding office closures, special events and updates or promotions. To opt-out of this service, simply notify us by phone at 403-938-4025 or email at healinghandswellness@telus.net.

☐ I agree to receive Healing Hands Family Wellness monthly newsletter containing chiropractic research, chiropractic testimonials and information pertaining to health and well-being. To opt-out of this service, simply notify us by phone at 403-938-4025 or email at healinghandswellness@telus.net.

The email I would like to have on file is a personal, non-shared, confidential email. I assure Healing Hands Family Wellness that information sent to this email is secure and does not place Healing Hands Family Wellness at risk of breaching confidentiality or privacy regulations.

The Statements made on this form are correct to the best of my knowledge and I consent to allow Healing Hands Family Wellness to use the said email I have provided.

Name: _____ **Signature:** _____

Parent or Guardian if under 18

Date: _____