full circle
A Collaborative Health Approach

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HEALTH INFORMATION FORM

Part 1: BASIC INFORMATION

Name: _____ Date:_____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Email: _____

Alberta Health Care number: _____

Sex: M F Date of Birth (mm-dd-yy): _____ Age: _____

Marital Status: single married divorced widowed separated common law

Occupation: _____ Employer: _____

Spouse/Partner's Name: _____ Phone: _____

Names of Children	
1	Age:
2	Age:
3	Age:
4	Age:

Emergency contact name: _____ Phone: _____

Whom may we thank for referring you to us? _____

Part 2: WELLNESS ASSESSMENT

What is the main issue or priority that you'd like to explore at your appointment?

_____

_____

_____

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We recognize that your health is more than physical, and that your social, intellectual, work, emotional, spiritual, and environmental health all interacts as a whole. Please place a ☑ for each question below so that we may better understand the areas that make up your whole health:

	Never	Sometimes	Often	Most of the time	All of the time
1. Physical (Exercise, Nutrition, and Healthy Body Habits)					
a) I get enough sleep and wake up feeling rested					
b) I get at least 2.5 hours of moderate physical activity every week.					
c) I eat regular healthy meals that give me enough energy to stay active through the day.					
2. Social (Relationships with Family, Friends, and Community Connections)					
a) I am able to find the time to maintain healthy relationships with people I care about.					
b) I feel a sense of belonging to a group in my community.					
c) I respect others and their unique identity.					
3. Intellectual (Interests, Hobbies and Creativity)					
a) I like to learn about different things, including current events.					
b) I seek out new challenges and goals.					
c) I have at least one activity outside of work that I enjoy.					
4. Work (Career, Academics and Finances)					
a) The work I do is personally rewarding.					
b) I am satisfied with my performance at work or school.					
c) I live within my means.					
5. Emotional (Feelings, Coping and Resiliency)					
a) I ask for help when I need it.					
b) I value and seek self-improvement.					
c) I am able to recognize my strengths and manage different stressors in my life.					
6. Spiritual (Values, Sense of Purpose, Connection to a 'Bigger Picture')					
a) I feel a sense of peace and wellbeing in my life.					
b) I believe that my life has direction and meaning.					
c) My own beliefs help me to respect others.					
7. Environmental (Food, Air, Water, Surroundings)					
a) My home has safe surroundings.					
b) I am aware of risks in my environment, and make changes for health and safety.					
c) I try to live an environmentally friendly life.					

Adapted from Simon Fraser University (2012) Wellness Quiz. Retrieved September 21, 2012 from http://students.sfu.ca/health/wellness/wellnessquiz.html

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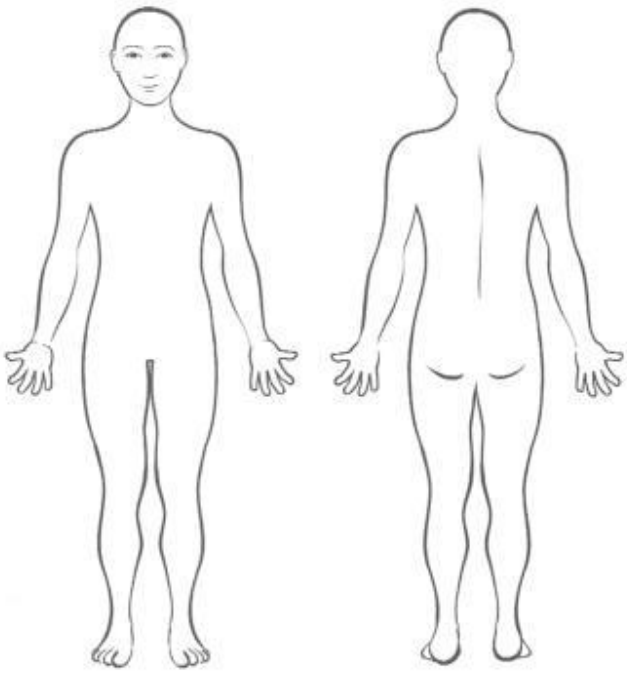
Please consider each part of this wellness circle. For each of the 7 sections, place a dot to indicate where you feel you are at on the wellness circle. The higher the number, the more satisfied you are. This will help us work together to find out your priorities for whole health care planning.

Part 3: CONCERNS

Current Health Condition
Current Concerns:

_____
_____
_____
_____

On the diagram to the right, circle where you have pain, numbness, or other concerns.



D = Dull
B = Burning
S = Stabbing / Sharp
T – Tingling (pins & needles)
C = Cramping
N = Numbness

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When did this concern begin? _____

Has this occurred before? Yes No

Is your concern getting: Worse Constant Comes/Goes Better

Is this concern job or auto accident related? Yes No
If so, when did the accident occur? _____

PLEASE NOTE THAT THIS OFFICE DOES NOT HANDLE WCB CLAIMS

Have you been treated by other healthcare providers for this condition? Yes No

Please list who has been involved in your care, treatments and results:

Health care provider name	Treatment	Results

Do you have any other condition than the one you are now consulting us for? Yes No
If so, please describe:

_____
_____
_____

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

What medications or supplements are you currently taking?:

_____
_____

Do you drink alcohol? Yes No
If yes, how many drinks do you typically have in one week: _____
Do you smoke or chew tobacco? Yes No
If yes, how much do you smoke/chew in one day:_____
Do you want to quit tobacco? Yes No

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Past Health History

Below is a list of health conditions which may seem unrelated to the purpose of your appointment. However, please answer these questions carefully as these issues may can affect your overall plan of care.
Check any of the following issues that you've had that have caused concern:

Chronic Conditions
- ☐ Allergies:
  _____
  _____
- ☐ Arthritis:
  _____
  _____
- ☐ Heart Disease/Stroke
  _____
- ☐ Diabetes: _____
- ☐ HIV / AIDS: _____
- ☐ Chronic Infections:
  _____
  _____
- ☐ Cancer:
  _____
  _____
- ☐ Other
  _____
  _____
  _____

Nervous System: Function & Feeling
- ☐ Seizures
- ☐ Confusion
- ☐ Forgetfulness
- ☐ Numbness/tingling
- ☐ Weakness/paralysis
- ☐ Poor Temperature Regulation
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Fainting
- ☐ Stress
- ☐ Depression
- ☐ Learning Disability
- ☐ Anxiety
- ☐ Mental health concerns

_____
_____
_____
_____
_____

Digestion: Eating & Elimination
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Abnormal Appetite
- ☐ Nausea
- ☐ Abdominal Cramps
- ☐ Vomiting
- ☐ Black or Bloody Stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ Weight gain or loss
- ☐ Other _____

Please describe:
_____
_____
_____

Heart & Lung Health
- ☐ Stroke
- ☐ Heart Problems
- ☐ Chest Pain
- ☐ Blood Pressure Problems
- ☐ Shortness of Breath
- ☐ Lung Problems or Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Asthma

- ☐ Other _____

Please describe:
_____
_____
_____

Eyes, Ears, Nose & Throat
- ☐ Vision Problems
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose
- ☐ Sinus Problems
- ☐ Dental Problems
- ☐ Ringing in ears
- ☐ Other _____

Please describe:
_____
_____
_____

Bones & Joints
- ☐ Difficulty Chewing
- ☐ Jaw Clicking
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Joint Pain or Stiffness
- ☐ Walking Problems
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Tight Muscles

- ☐ Other _____

Please describe:
_____
_____
_____

Reproductive and Urinary Health
- ☐ Bladder Trouble
- ☐ Painful or Excessive Urination
- ☐ Discolored Urine
- ☐ Sexual Dysfunction or concerns
- ☐ Incontinence - Bladder
- ☐ Incontinence - Bowel
- ☐ Other _____

Please describe:
_____
_____

Women Only:
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain or Infections
- ☐ Breast Pain or Lumps
- ☐ Menopause

When was your last period?
_____

Are you pregnant?
Yes No Not Sure

Men Only:
- ☐ Prostate concerns

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Major Surgery/Operations: Yes No If so, please describe:

Broken bones, ligament sprain, muscle strain: Yes No If so, please describe:

Previous accidents & injuries: Yes No If so, please describe:

Previous hospitalizations: Yes No If so, please describe:

Current or past use of:

Blood thinners: _____

Corticosteroids: _____

Prolotherapy: _____

Are there functional restrictions at work or home: Yes No If so, please describe:

What are your current recreational activities / sports?

What is your goal with therapy?

Other important issues:

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There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this_____ day of_____, 20_____.

_____ _____

Patient Signature (Legal Guardian) **Witness of Signature**

Name:_____ **Name:_____**

Print Name **Print Name**

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and that I give permission to the doctors and/or licensed staff at Full Circle Collaborative Health to perform an x-ray evaluation (if needed). I understand that x-rays pose a potential risk to the health and welfare of a developing child.

Signature:_____