DR. BRIAN DOWER ❖ CHIROPRACTOR
PARK ROAD HEALING ARTS
28 PARK ROAD, TORONTO, ONTARIO, M4W 1M1 ☎ (416) 920-7275 FAX (416) 920-7274

Confidential Case History

We are pleased that you have chosen to consult us regarding your health. In order to help us evaluate your condition thoroughly, please complete the following form accurately. Please ask for assistance if needed.

Name: ____ Referred By: ________________________________

Address: _________________________________Apt. #: _____ City: ________________ Postal Code:______________

- May we mail correspondence to the above address? Yes ___ No ___

Home Phone: _____________________Work Phone: ________________________ Cell Phone: ___________________

- Preferred phone number to leave messages: home ___ work___ cell___

E-mail: ____________________________________ (you will receive important info on your care to this address)

Birthdate (DDMMYY):_________________________ Age: ___________________________________ Gender : M F T

Occupation: _______________________________ Name of Business: ______________________________________

Type of Work: ______________________________ Hours Work/Study per week: _____ Computer Hours per day: ______

Medical Doctor's Name: ________________________________MD's Address: _________________________________

Naturopathic Doctor's Name: _____________________________ Massage Therapist's Name: ______________________

Emergency Contact (name/phone #/relationship to you) ____

- May we send a thank you to the person who referred you to our office for care? Yes ___ No___

Your Health Profile

If you have no symptoms or complaints, and are here for wellness services, please check here _____, and move to section B below. Those who have symptoms or complaints need to briefly describe the chief area of complaint, including the NEGATIVE IMPACT it has had on your QUALITY OF LIFE.

A) Reason for attending our office: ____

Location of pain? ____

Best words to describe pain? __________________________ How long have you had this condition?_________________

Have you had this (or similar) conditions in the past?_________________ Is the pain local or radiating? ________________

On a scale of 1 to 10 (10 being worst pain ever felt), please rate pain: today _____ at its best _____ and at its worst _______

Pain aggravated by? ____

Pain relieved by? ____

Is condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

How is this negatively affecting:

Your Family Life? ____________________________ Your Career? ____

Your Social Life? ____________________________ Your Physical Health & Recreation? ___________________

Your Emotional Life? _________________________ Your Energy/Concentration? _________________________

Your Sleep Quality & Quantity? _________________

B) Have you had previous chiropractic care? ☐ **Yes** ☐ **No**

Where?__________________________________ When? ____

Why? ___________________________________ Were X-Rays taken? ☐ Yes ☐ No

Other treatments tried? ____

C) How long has it been since you felt really good? ________________________**Date of last physical** _____________

List any **medications** you are taking:____

List any **supplements/vitamins** you are taking: ____

Other health problems?____

List surgical operations (and dates): ____ ____Pregnancies? _______________

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office and offer you the opportunity of improved health potential and wellness services in the future. 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 health potential.

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 (your own birth)			Yes	No	
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	
Stomach sleeping	C	T	A	N	(Hrs of sleep/night ____)

II. CHEMICAL STRESS:

					Explain
Smoker – Amount? _____	C	T	A	N	
Second-Hand Smoke	C	T	A	N	
Poor Diet	C	T	A	N	(# of meals/day ____)
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	
Alcohol consumption	C	T	A	N	(# of drinks/week __)

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?

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DR. BRIAN DOWER, 28 PARK ROAD TORONTO ONTARIO M4W 1M1 **Your name:________________________**

Please check all symptoms you have had in the last year:

☐ Headaches	☐ Dizziness or vertigo	☐ Fainting	☐ Depression
☐ Pins & needles in arms	☐ Loss of smell	☐ Back pain	☐ Loss of balance
☐ Pins & needles in legs	☐ Buzzing/ringing in ears	☐ Loss of concentration	☐ Nervousness
☐ Numbness in toes/feet	☐ Cold sweats	☐ Loss of taste	☐ Upset stomach
☐ Numbness in hands	☐ Neck pain	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Stiff neck	☐ Cold hands	☐ Fever
☐ Diarrhea or constipation	☐ Arm pain	☐ Cold feet	☐ Hot flashes
☐ Fatigue	☐ Sensitive eyes	☐ Problem urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual pain/ irregularity	☐ Teeth grinding	☐ Stroke
☐ Blurred vision	☐ High blood pressure	☐ Asthma	☐ Sinusitis
☐ Difficulty breathing	☐ Difficulty speaking	☐ Sudden weakness	☐ Difficulty walking

A) Anything else you feel we should know about: ____

____

B) Any recent infections or illnesses? ____

C) Current exercise levels? (what and how often?) ____

Imagine you could **wish for 5 things to change about your health** in the year to come. What would they be (think big!). What would you like to do that you currently feel you can't do?

1. ____
2. ____
3. ____
4. ____
5. ____

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. Many health problems are the result of hereditary spinal weaknesses, thus, information about your family members will give us a better picture of your total health. Please mention below any health conditions or concerns you may have about your:

Children: ____
Spouse: ____
Mother: ____
Father: ____
Brother(s): ____
Sister(s): ____
Others: ____

People go to Chiropractors for a variety of reasons. Some seek care for relief of pain and discomfort only. Others wish to correct the underlying cause of the problem, to increase their health potential and prevent the problem from returning. Please check which type of care you are seeking:

☐ Relief Care ☐ Correction ☐ Wellness

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

____ ____
Signature Date