

INNER HARMONY FAMILY CHIROPRACTIC

DR. DAVID VECCHIO, D.C.

272 ST. MARIE STREET

COLLINGWOOD, ON L9Y 3K7

(705) 446-9690

CONFIDENTIAL CLIENT HEALTH PROFILE

Name: _____ Date: _____

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

Address: _____ Town: _____ Postal Code: _____

Home# _____ Work# _____ Cell# _____

Email: _____ (we do not trade/share any of our email addresses)

Marital Status: _____ Name of Spouse/Partner: _____

Children: yes ___ no ___ How many? _____ Indicate if you are or may be pregnant ()

Place of Employment: _____ Occupation: _____

How did you hear about our office? _____

(Please be specific)

Main reason for consulting our office today? _____

What goals would you like to achieve for your health? _____

Describe problem areas of concern: _____

When did this problem start? _____

How often does this problem affect you? _____

What makes this problem worse? _____

What makes this problem better? _____

How does this affect your family life? _____

How does this affect your work? _____

How does this affect your ability to enjoy sports/hobbies? _____

Rate your commitment level to assisting us in your care. (1-low, 10-high) _____

Rate your commitment level to achieving your health goals. (1-low, 10-high) _____

Previous Chiropractic Care: No () Yes () Date of last chiropractic visit _____

Chiropractor Name: _____ X-Rays taken: No () Yes ()

Personal Habits: (Please specify if Heavy, Moderate, Light or N/A)

Alcohol _____ Coffee/Tea/Cola _____ Tobacco _____ Prescription Drugs _____

Please list your current medications and what they are for: _____

How well do you sleep? _____

Please list any broken bones, injuries, accidents, falls or surgeries you have ever experienced.

Please check the conditions you experience frequently or are currently experiencing.

HEAD/NECK:

headaches/migraines ____ vision problems ____ earaches/ear noises ____ ear infections ____

RESPIRATORY:

chronic cough ____ shortness of breath ____ allergies/sinus ____ asthma ____
recurrent colds/infections ____ breathing problems ____

CARDIOVASCULAR:

high/low blood pressure ____ poor circulation ____ heart disease ____
varicose veins ____ phlebitis ____

DIGESTIVE/URO-GENITAL:

difficult digestion ____ constipation ____ liver/gall bladder ____ kidney/bladder ____

OTHER CONDITIONS:

insomnia ____ nervousness/anxiety ____ weight issues ____ thyroid ____
cancer ____ arthritis ____ diabetes ____ menopausal/menstrual issues ____

MUSCLES & JOINTS: (Current/Past Pain or Stiffness)

neck ____ shoulders ____ upper back ____ mid-back ____ low back ____
knees ____ elbows ____ legs ____ ankles ____ hips ____ wrists ____
other _____

OTHER CONDITIONS OR CONCERNS: _____

I have read and agree that all information is accurate to the best of my knowledge. I also agree, that once explained to me, I will participate in my health care and policies and agreements that go with my chiropractic care. I understand and agree that health and accident insurance policies are an arrangement between myself and the carrier. I will be provided all the necessary receipts to be reimbursed. I understand that if I suspend or terminate my care, all fees are due and payable for services rendered. I hereby consent to a preliminary consultation, examination, scans or other diagnostic testing that will assist the doctor in determining if I am a chiropractic case. If chiropractic care is prescribed, I also agree to chiropractic adjustments, based on my decision to choose chiropractic care. I understand and agree that as in all health care, there are some slight risks and that I have been examined in order to determine if I am at risk and the doctor has explained all aspects of my care. I will rely on the doctor's judgement during my course of care. I intend this consent to cover the entire course of my care in this clinic.

Patient Signature: _____ **Date:** _____

Witness Signature (C.H.A.) _____