TURNER WELLNESS AND BRAIN CARE CENTRE DATE_____

PLEASE PRINT CLEARLY

LAST NAME_____ FIRST NAME_____INITIAL_____

ADDRESS_____CITY_____P.CODE_____

TELEPHONE: HOME_____WORK _____ EXT _____

DATE OF BIRTH: DAY_____MONTH _____YEAR_____AGE_____SEX: M _____ F _____

OCCUPATION _____MARITAL STATUS: _____

NUMBER OF CHILDREN_____REFERRED BY_____

***E-MAIL_____**

PLEASE INDICATE (CIRCLE) THOSE CONDITIONS THAT APPLY TO YOU

GENERAL
ALLERGY
CHILLS
CONVULSIONS
DIZZINESS
FAINTING
FATIGUE
FEVER
HEADACHES
LOSS OF SLEEP
WEIGHT LOSS
NERVOUSNESS
NEURALGIA
NUMBNESS
SWEATS
TREMORS

MUSCLES & JOINTS
ARTHRITIS
BURSITIS
FOOT TROUBLE
HERNIA
LOW BACK PAIN
NECK PAIN OR STIFF
PAIN BETWEEN
SHOULDERS
ARMS
ELBOWS
HANDS
HIPS
LEGS
KNEES
FEET
PAINFUL TAILBONE
POOR POSTURE
SCIATICA
SPINAL CURVATURE
SWOLLEN JOINTS

LEARNIND DISABILITY
MATH
MEMORY
SPEECH
READING

GASTRO-INTESTINAL
ABDOMEN DISTENTION
BELCHING OR GAS
COLITIS
COLON TROUBLE
CONSTIPATION
DIARRHEA
DIFFICULT DIGESTION
EXCESSIVE HUNGER
GALL BLADDER PAIN
HEMORRHOIDS
INTESTINAL WORMS
JAUNDICE
LIVER TROUBLE
NAUSEA
PAIN OVER STOMACH
POOR APPETITE
VOMITING
VOMITING OF BLOOD

EYES, EARS, NOSE AND THROAT
ASTHMA
COLDS
CROSSED EYES
DEAFNESS
DENTAL CARE
EARACHE
EAR DISCHARGE
EAR NOISES
ENLARGED GLANDS
ENLARGED THYROID
EYE PAIN
FAILING VISION
FARSIGHTEDNESS
GUM TROUBLE
HAY FEVER
HOARSENESS
NASAL OBSTRUCTION
NEARSIGHTEDNESS
NOSE BLEEDS
SINUS INFECTION
SORE THROAT
TONSILLITIS

CARDIOVASCULAR
HARDENING ARTERIES
HIGH BLOOD PRESSURE
LOW BLOOD PRESSURE
PAIN OVER HEART
POOR CIRCULATION
RAPID HEART BEAT
SLOW HEART BEAT
SWELLING ANKLES

RESPIRATORY
CHEST PAIN
CHRONIC COUGH
DIFFICULT BREATHING
SPITTING BLOOD
SPITTING UP PHLEGM
WHEEZING

SKIN
BOILS
BRUISE EASILY
DRYNESS
HIVES OR ALLERGY
ITCHING
SKIN ERUPTIONS
VARICOSE VEINS

GENITO-URINARY
BED WETTING
BLOOD IN URINE
FREQUENT URINATION
INABILITY TO CONTROL
KIDNEYS
KIDNEY INFECTION
KIDNEY STONES
PAINFUL URINATION
PROSTATE TROUBLE
PUS IN URINE

FOR WOMEN ONLY
CONGESTED BREASTS
CRAMPS OR BACKACHE
EXCESSIVE MENSES
HOT FLASHES
IRREGULAR CYCLE
LUMPS IN BREASTS
MENOPAUSE SYMPTOMS
VAGINAL DISCHARGE
YEAST INFECTIONS

OTHER
ALCOHOLISM
ANEMIA
APPENDICITIS
ARTERIOSCLEROSIS
BULIMIC
CANCER
CHOLERA
COLD SORES
DIABETES
DIPHTHERIA
ECZEMA
EMPHYSEMA
EPILEPSY
FEVER BLISTERS
GOITER
GOUT
HEART DISEASE
INFLUENZA
LUMBAGO
MALARIA
MEASLES
MISCARRIAGE
MULTIPLE SCLEROSIS
MUMPS
PLEURISY
POLIO
RHEUMATIC FEVER
SCARLET FEVER
STROKE
TUBERCULOSIS
TYHIOD FEVER
ULCERS
VENEREAL DISEASE
WHOOPING COUGH

STRESS SYMPTOMS
DIZZINESS
BLURRED VISION
RINGING IN EARS
LOW RESISTANCE
NERVOUSNESS
DEPRESSION
IRRITABILITY

SPECIAL NEEDS
AUTISM
DOWNS SYNDROME
RHETTS
ADD, ADHD
BEHAVIOUR ISSUES
FAILURE TO THRIVE
OCD, ODD
PDD
ASPERGERS
FAILURE TO LATCH

ANYTHING ELSE
_____
_____
_____
_____
_____

MAJOR HEALTH CHALLENGE: **NAME:**

_____
_____
_____

HOW LONG HAVE YOU HAD IT_____
TREATMENT RECEIVED_____
WHAT CAUSED IT_____

OTHER HEALTH CONDITIONS _____
_____

HEAD INJURIES: (DESCRIBE INCIDENT AND DATE)

BIRTH PROCESS_____
FALLS WHEN LEARNING TO WALK_____
FALLS FROM CHANGE TABLE OR BED_____
HITTING HEAD ON COFFEE TABLE OR FLOOR_____
CHILDHOOD ACCIDENTS_____
SPORTS INJURIES_____
CAR ACCIDENTS_____
INDUSTRIAL ACCIDENTS _____
PHYSICAL ABUSE

LIST OTHER FALLS: (HORSE, SNOWMOBILE, SLIP ON ICE, ETC.)
_____
_____

WHAT THINGS DO YOU DO ON A REGULAR BASIS FOR YOUR HEALTH?

EXERCISE_____ _____
VITAMINS/SUPPLEMENTS_____
CLEANSING, YOGA, STRETCHING _____
SLEEPING POSITION: STOMACH_____ **SIDE**_____ **BACK**_____

SITTING POSITION: SLOUCHED **LEGS CROSSED** **ERECT**

DIET

Blood Type: _____

HOW MUCH DO YOU EAT OR DRINK OF THE FOLLOWING FOODS, PER DAY?
FRUIT_____**VEGETABLES** _____ **RED MEAT** _____
FIBER _____ **FAT** _____ **MILK** _____
COFFEE _____ **TEA (REGULAR)** _____ **TEA (HERBAL)** _____
SUGAR _____ **SALT** _____**WHITE FLOUR** _____
ALCOHOL (DRINKS PER DAY)_____**CIGARETTES** (PACKS PER DAY) _____
POP/DIET POP _____**MSG / FOOD COLOURING** _____
WATER (TYPE AND AMOUNT)_____

DESCRIBE A TYIPICAL DAYS MENU:

BREAKFAST_____
LUNCH_____
DINNER_____
SNACKS

STRESS:

IS THERE ANY STRESSFUL EVENTS OCCURING IN YOUR LIFE? (EG. DIVORCE, SICKNESS IN FAMILY)
BRIEF DESCRIPTION: _____
_____

DO YOU HAVE A RECURRING EMOTIONAL STATES? _____
(ANGER, PERFECTION, DEPRESSION, HATE) _____

IS THERE ANY SITUATION SUPPRESSING YOU? _____
(WORK, SPOUSE, FINANCES)_____

WHAT DO YOU WORRY ABOUT MOST?_____

IS THERE ANYTHING THAT IS INTERFERING WITH YOUR ABILITY TO GET WELL?

ARE YOU GOOD AT KEEPING YOUR WORD AND FOLLOWING THROUGH WITH YOUR COMMITMENTS?

MEDICAL HISTORY: **NAME:**

LIST SURGICAL PROCEDURES WITH DATES _____
_____
_____

LIST ALL DRUGS PRESENTLY TAKEN (PRESCRIPTION OR OVER THE COUNTER eg. BIRTH CONTROL, ANTACIDS, TYLENOL)
_____
_____
_____

HAVE YOU BEEN X-RAYED IN THE PAST 6 MONTHS? YES_____NO_____WHERE_____
ARE YOU PREGNANT? _____ LAST PERIOD? _____

HAVE YOU EVER BEEN TO A CHIROPRACTOR? YES_____NO_____
WHO? _____ WHEN? _____

WHAT TYPE OF CARE IS AVAILABLE? PLEASE CIRCLE THE TYPE OF CARE DESIRED

RELIEF CARE: PEOPLE GO TO CHIROPRACTORS FOR A VARIETY OF REASONS. SOME GO FOR SYMPTOMATIC RELIEF OF PAIN OR DISCOMFORT.

CORRECTIVE CARE: OTHERS ARE INTERESTED IN HAVING THE CAUSE OF THE PROBLEM AS WELL AS THE SYMPTOMS CORRECTED AND RELIEVED.

COMPREHENSIVE CARE: STILL OTHERS WANT THEIR BODIES BROUGHT TO THE HIGHEST STATE OF HEALTH POSSIBLE.

WHAT WOULD YOU LIKE US TO HELP YOU ACHIEVE?
WHAT IS YOUR VISION FOR YOUR HEALTH?
_____
_____
_____
_____

How committed are you to follow through with your treatment recommendations?
Rate yourself from 1 to 10_____

The purpose of our chiropractic center is to support each individual in achieving their optimum health and to educate them so that they may understand health and Chiropractic and in turn educate others.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctor's office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, all fees for professional services rendered to me will be immediately due and payable.

Overdue accounts are subject to 2% per month charge and
a $50.00 charge for each attempt we make to contact you for payment.

PATIENT'S SIGATURE _____

GAURDIANS SIGNAT URE _____**DATE** _____

TURNER WELLNESS **BARRIE 705-735-6999** **TORONTO 416-534-8971**