DR. NOREEN YEATES

insideout chiropractic
Spinal health and wellness centre

Name:_____ D.O.B. (M)_____ (D)_____ (Y)_____ Sex: M/F

Address:_____ Province:_____ Postal Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Workplace:_____ Occupation:_____

Email Address:_____ Family Doctor:_____

Marital Status: M S W D Spouse's Name:_____

# of Children:_____ and their ages:_____

Height:_____ Weight:_____

Do you have Extended Health Benefits? ☐ Yes or No ☐ Company:_____

Whom may we thank for referring you? _____

HEALTH GOALS

☐ **SYMPTOM RELIEF**: I only want pain relief

☐ **CORRECTION OF THE PROBLEM**: In addition to pain relief, I want a full report of my condition and recommendations for correction.

☐ **OPTIMIZING HEALTH:** I have no symptoms at present but am interested in having a spine and nervous system evaluation and report.

LIFESTYLE HISTORY

Do you smoke?	**YES** ☐	**NO** ☐
Do you drink 6 – 8 glasses of water per day?	**YES** ☐	**NO** ☐
Do you drink fewer than 2 caffeinated beverages per day?	**YES** ☐	**NO** ☐
Do you drink one or more alcoholic beverages per day?	**YES** ☐	**NO** ☐

On a scale of Poor, Good, Excellent, describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

What is your sleeping posture? ☐ Side ☐ Stomach ☐ Back

Are you under stress at: ☐ Work ☐ Home ☐ School

Do you take any vitamins, herbs or other supplements? ☐ Yes ☐ No

Please list:_____

What are your hobbies?_____

Do you wear ☐ Heel lifts ☐ Arch supports ☐ Orthotics

PERSONAL HEALTH HISTORY

Have you had any serious falls as a child or adult? YES ☐ NO ☐ UNSURE ☐

Has there been prolonged use of antibiotics or inhalers? YES ☐ NO ☐ UNSURE ☐

Did/do you play sports? YES ☐ NO ☐

Have you fallen/jumped from a height over 3 feet? YES ☐ NO ☐ UNSURE ☐

Have you been in any car accidents? YES ☐ NO ☐

Are you currently or do you regularly suffer from the following symptoms:

☐ headaches	☐ chest pain	☐ numbness in toes	☐ fever
☐ neck pain	☐ dizziness	☐ shortness of breath	☐ fainting
☐ back pain	☐ face flushes	☐ fatigue	☐ loss of smell
☐ nervousness	☐ pins and needles in legs	☐ depression	☐ loss of taste
☐ stomach upset	☐ pins and needles in arms	☐ lights bother eyes	☐ diarrhea
☐ constipation	☐ numbness in fingers	☐ loss of memory	☐ feet cold
☐ hands cold	☐ cold sweats	☐ loss of balance	☐ ears ring
☐ eye problems	☐ dental problems	☐ hearing problems	

Is there a family history of: ☐Heart Disease ☐ Cancer ☐Diabetes ☐Other_____

List any medications you are taking:_____

List all surgical operations and years:_____

_____

Have you had x-rays taken? ☐ Yes ☐ No For what part of the body?_____

When were they taken?_____ Where were they taken?_____

Have you had previous chiropractic care? _____ Where? _____

How long ago? _____ Why? _____

Were you satisfied with the results? ☐ Yes or ☐ No Explain_____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

Briefly describe your symptoms:_____

If you have **no** symptoms and are here for wellness services, please check (√) here ___
"Wish to have Chiropractic Wellness services" and skip to "Family Health Profile".

If you are experiencing pain, is it: ☐ Sharp ☐ Dull ☐ Comes and goes ☐ Constant

Since the problem started, is it: ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse? _____

What makes it better? _____

Does it interfere with any of the following?
☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

FAMILY HEALTH HISTORY

FAMILY HEALTH is important to us. We are committed to helping parents raise healthy children in a supportive environment with minimal intervention.
CHIROPRACTIC care has proven beneficial for many common health problems. Below is a list of some of the most frequent/commonly seen in our off ice. Please check if any of these are a concern in your family.

☐ Asthma	☐ Chronic stomach problems	☐ Diarrhea/Constipation
☐ Bedwetting	☐ Frequent Colds and Flu	☐ ADD/ADHD
☐ Colic	☐ Ear Infections	☐ Headaches
☐ Allergies	☐ "Growing" Pains	☐ Poor Posture
☐ Frequent Falls	☐ Other_____	

The statements on this form are accurate to the best of my recollection and knowledge.

_____ _____
Signature of Patient Date (mm/dd/yy)

PERMISSION TO DISCLOSE HEALTH INFORMATION

I authorize Dr. Noreen Yeates – Insideout Chiropractic, to release information related to my health condition and treatment received at this facility, including x-rays, examination findings, hospital and medical records or reports. Please check off any or all of the following to provide consent: (√)

☐ insurance

☐ x-ray/radiology clinic

☐ medical doctor

☐ personal trainer/gym

☐ massage therapist

☐ naturpath

☐ other

Permission is valid on a continuing basis from the date this form is signed.

_____ _____
Signature of Patient Date (mm/dd/yy)