

Welcome to Wholelife Wellness! We are honoured to meet you!

(Please Print Clearly)

Date: _____

Name: _____ Birthdate: _____
E-mail Address: _____ mm/dd/yyyy
Home Phone: (____) _____ Age: _____
Cell Phone: (____) _____ Cell Phone Service Provider: _____
Work Phone: (____) _____ Occupation: _____
Home Address: _____ City: _____ Postal Code: _____
Provincial Health #: _____ Height: _____ ft. _____ inches Weight: _____ lbs.
Marital Status: M S D W Number of children: _____ Spouse/Parent's Name: _____
Who may we thank for referring you to our office? _____
Have you received Chiropractic care in the past? _____ If yes, when? _____
For you, is Chiropractic a way to decrease your symptoms or improve your quality of life? (Underline)

Lifestyle

Please circle your current level of stress: Absent 0—1—2—3—4—5—6—7—8—9—10 Severe
How many cups of water do you drink in a typical day? _____
How much coffee, tea, and pop (combined) do you drink in a typical day? _____
How many alcoholic beverages do you drink in a typical week? _____
How many servings of raw fruits and vegetables do you eat in a typical day? _____
How many times in a typical week do you eat in a restaurant? _____
Do you currently use dietary supplements? _____ If so, which ones? _____
How many different drugs (prescribed or over-the-counter) have you taken in the past month? _____
How many days in a typical week do you engage in exercise, excluding work? _____
How many hours in a typical day do you spend sitting (at work/in class, at home, driving, etc.)? _____
How many hours in a typical day do you spend on your feet? _____ Mostly what type of surface? _____
Are you, or have you been, a smoker? _____ If yes, for how many years? _____
How many times per day do you brush your teeth? _____
Do you consider yourself a positive or a negative person? _____
Do you weigh more than you think you should? _____
How many hours of sleep do you get in a typical night? _____ Do you work shift work? _____

Current Complaint(s)

List your chief complaints in order of severity:

(1) _____ For how long? _____
(2) _____ For how long? _____
(3) _____ For how long? _____

Please circle your level of discomfort as it relates to your main complaint today:

Absent 0—1—2—3—4—5—6—7—8—9—10 Severe

Are your symptoms: () getting better () getting worse () staying the same
Are any of these complaints from a recent work-injury? _____ If yes, have you told your employer? _____
Are any of these complaints related to a car accident? _____ If yes, have you reported it to SGI? _____
Do you have any diagnosed medical conditions? _____
If yes, please list: _____

How serious are you about improving your long-term health and wellness? (Please circle)

Not Serious 0—1—2—3—4—5—6—7—8—9—10 Very Serious