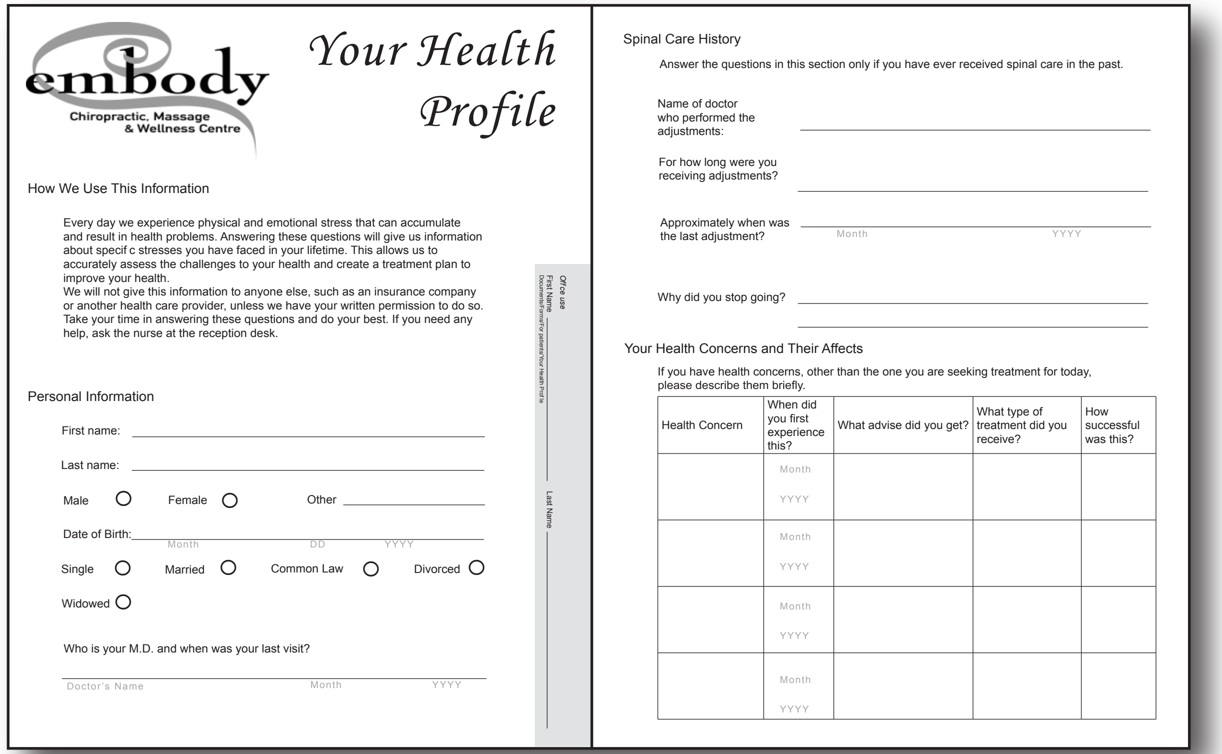


embody
Chiropractic, Massage & Wellness Centre

Your Health Profile

How We Use This Information

Every day we experience physical and emotional stress that can accumulate and result in health problems. Answering these questions will give us information about specif c stresses you have faced in your lifetime. This allows us to accurately assess the challenges to your health and create a treatment plan to improve your health.
We will not give this information to anyone else, such as an insurance company or another health care provider, unless we have your written permission to do so. Take your time in answering these questions and do your best. If you need any help, ask the nurse at the reception desk.

Personal Information

First name: ______

Last name: ______

Male ○ Female ○ Other ______

Date of Birth: ______ Month DD YYYY

Single ○ Married ○ Common Law ○ Divorced ○

Widowed ○

Who is your M.D. and when was your last visit?

______ Doctor's Name Month YYYY

Spinal Care History

Answer the questions in this section only if you have ever received spinal care in the past.

Name of doctor who performed the adjustments: ______

For how long were you receiving adjustments? ______

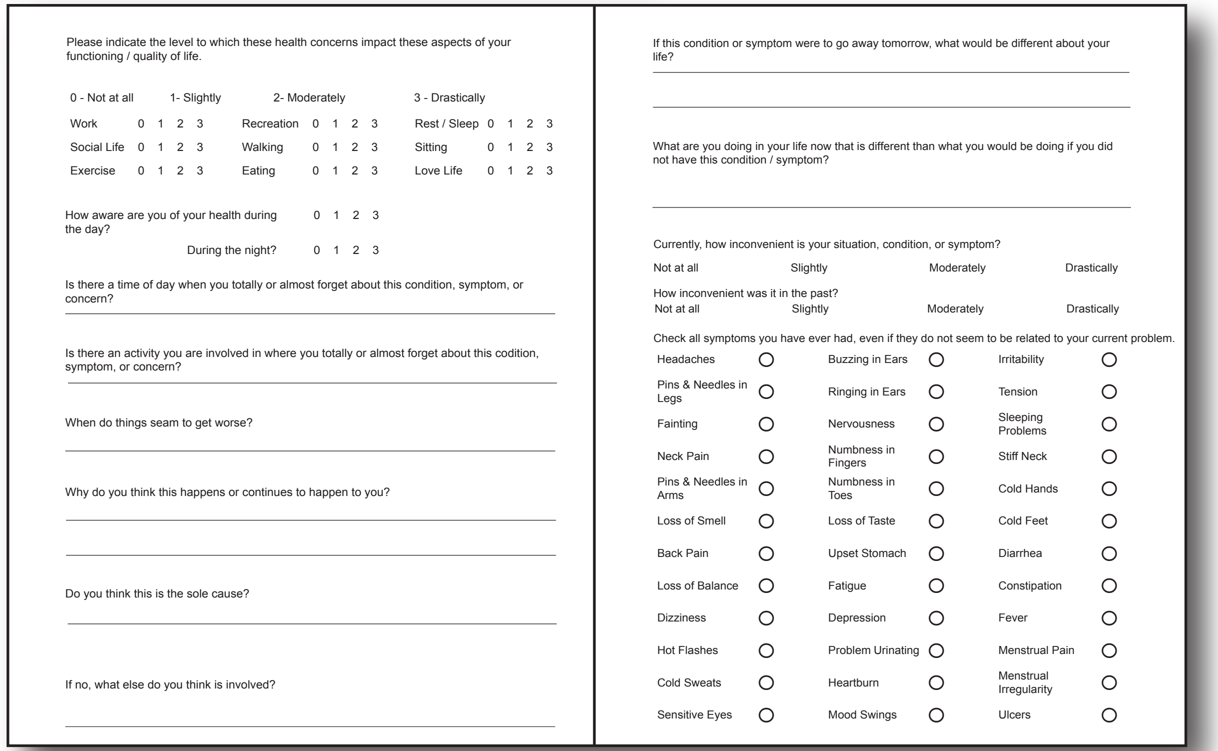
Approximately when was the last adjustment? ______ Month YYYY

Why did you stop going? ______

Your Health Concerns and Their Affects

If you have health concerns, other than the one you are seeking treatment for today, please describe them briefly.

Health Concern	When did you first experience this?	What advise did you get?	What type of treatment did you receive?	How successful was this?
	Month YYYY			
	Month YYYY			
	Month YYYY			
	Month YYYY			



Please indicate the level to which these health concerns impact these aspects of your functioning / quality of life.

0 - Not at all 1- Slightly 2- Moderately 3 - Drastically

Work	0 1 2 3	Recreation	0 1 2 3	Rest / Sleep	0 1 2 3
Social Life	0 1 2 3	Walking	0 1 2 3	Sitting	0 1 2 3
Exercise	0 1 2 3	Eating	0 1 2 3	Love Life	0 1 2 3

How aware are you of your health during the day? 0 1 2 3

During the night? 0 1 2 3

Is there a time of day when you totally or almost forget about this condition, symptom, or concern?

Is there an activity you are involved in where you totally or almost forget about this codition, symptom, or concern?

When do things seam to get worse?

Why do you think this happens or continues to happen to you?

Do you think this is the sole cause?

If no, what else do you think is involved?

If this condition or symptom were to go away tomorrow, what would be different about your life?

What are you doing in your life now that is different than what you would be doing if you did not have this condition / symptom?

Currently, how inconvenient is your situation, condition, or symptom?
Not at all Slightly Moderately Drastically

How inconvenient was it in the past?
Not at all Slightly Moderately Drastically

Check all symptoms you have ever had, even if they do not seem to be related to your current problem.

Headaches ○	Buzzing in Ears ○	Irritability ○
Pins & Needles in Legs ○	Ringing in Ears ○	Tension ○
Fainting ○	Nervousness ○	Sleeping Problems ○
Neck Pain ○	Numbness in Fingers ○	Stiff Neck ○
Pins & Needles in Arms ○	Numbness in Toes ○	Cold Hands ○
Loss of Smell ○	Loss of Taste ○	Cold Feet ○
Back Pain ○	Upset Stomach ○	Diarrhea ○
Loss of Balance ○	Fatigue ○	Constipation ○
Dizziness ○	Depression ○	Fever ○
Hot Flashes ○	Problem Urinating ○	Menstrual Pain ○
Cold Sweats ○	Heartburn ○	Menstrual Irregularity ○
Sensitive Eyes ○	Mood Swings ○	Ulcers ○

2 Form Design

There's a lot of information to gather from a patient before they are seen by a healthcare professional. Also, it is important not to overburden patients with cumbersome paperwork. In this Visual Communications assignment, the challenge was to capture quality patient information while adding integrity it. To the user of this form, information is findable and usable.