Dr. Sandra J. Malpass D.C.
Advanced Proficiency Activator
Pediatric Certification I.C.P.A.
30+ years experience Family Chiropractor

356 Wilson Street East
Ancaster, ON L9G 2C2

Name: _____ Date: _____

Address:_____ City:_____ Postal Code:_____

Telephone (Res):_____-_____-_____ (Bus):_____-_____-_____ (Cell):_____-_____-_____

Date of Birth:_____ Gender:_____ Male _____Female
D M Y

E-Mail Address:_____

Number of Children and Ages:_____ Extended Health Insurance?_____Yes _____No

Occupation:_____

Referred by:_____

YOUR HEALTH PROFILE

Our purpose is to improve your Function and Quality of Life. Everyday, we experience Stressors in our life that can accumulate and result in the loss of normal function. By answering the following questions, we can assess the challenges these Lifestyle Stressors have on your quality of life.

YOUR CHILDHOOD YEARS (To Age 15)

	Yes	No	Unsure
Did you have any childhood illnesses?	_____	_____	_____
Was there prolonged use of medicine such as antibiotics or an inhaler?	_____	_____	_____
Did you have any surgery?	_____	_____	_____
Did you have any serious falls or jumps as a child?	_____	_____	_____
Were you involved in any car accidents?	_____	_____	_____
Did you suffer any trauma (physical or emotional)?	_____	_____	_____
Did you play youth sports?	_____	_____	_____
As a child, were you under regular Chiropractic care?	_____	_____	_____

What brings you to Malpass Family Chiropractic (your health concerns)?

THE ADULT YEARS (16 to Present)

Health Concerns (Please list according to severity)	How long have you had this condition?	Is it Better?	Worse?	Comes & Goes?
1.				
2.				
3.				
4.				

Is it interfering with any of the following?

Work_____ Sleep_____ Daily Routine_____ Sports/Exercise_____

Other (please explain)_____

List any accidents, falls and/or injuries _____

List any surgeries _____

List any medication, vitamins or nutritional supplements _____

Do you wear orthotics? _____Yes _____No

Other Doctors seen for this? _____Yes _____No Who/When? _____

Previous Chiropractic care? _____Yes _____No Who/When?_____

Family Doctor:_____ Dentist:_____

Please list any Lifestyle Stressors you have had:

1. Physical stress (falls, accidents, work posture, etc.) _____

2. Biochemical/environmental stress (smoke, drugs, alcohol, unhealthy diet, etc.) _____

3. Mental/emotional stress (work, relationships, finances, etc.) _____

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

Diet_____ Exercise_____ Type of Exercise_____ Sleep_____

How do you sleep? Back_____ Side_____ Stomach_____

Rate your Present level of Stress:

Very Low Very High

0_____10

Please **Check** all Symptoms you have ever had, even if they do not seem related to your current condition:

_____Headaches
_____Neck Pain or Stiffness
_____Pins and Needles in Arm
_____Numbness in Fingers
_____Dizziness
_____Loss of Balance
_____Buzzing or Ringing in Ears
_____Sinus Problems
_____Irritability
_____Sleep Problems
_____Heartburn
_____Shortness of Breath
_____Chest Pain
_____Stomach Upset
_____Pain Between Shoulder Blades
_____Fatigue
_____Low Back Pain
_____Tension
_____Pins and Needles in Leg
_____Numbness in Toes
_____Constipation
_____Diarrhea
_____Problem Urinating
_____Menstrual Pain or Irregularity
_____Cold Hands
_____Cold Feet

FAMILY HISTORY

	Heart Disease	Arthritis	Cancer	Diabetes	Other:
Father's Side	_____	_____	_____	_____	_____
Mother's Side	_____	_____	_____	_____	_____

WOMEN ONLY

Date of Last Menstrual Cycle (Start): _____

No possibility of Pregnancy Due to: Abstinence_____ Birth Control Pill _____

I.U.D._____ Other_____