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Wellness Centre
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Update

Have there been any changes in your address or phone numbers

Since we last saw you? If yes, please complete the following.

NAME: _____

ADDRESS: _____

CITY: _____ PROVINCE: _____

POSTAL CODE: _____ PHONE #: _____

CELL PHONE: _____

E- MAIL ADDRESS: _____

OCCUPATION: _____ PHONE #: _____

(PLEASE CIRCLE YOUR ANSWER TO EACH QUESTION. IF YES, PLEASE EXPLAIN)

1. What is your main problem? _____

2. What makes it feel better? _____

3. What makes if feel worse? _____

4. How long have you had this condition? _____

5. Have you had this or a similar condition in the past? Yes No

If so, when? _____

6. Is this condition getting progressively worse? Yes No

If so, when did it get worse? _____

7. Is this condition interfering with your:

☐ Work ☐ Sleep ☐ Daily Routine

☐ Sitting ☐ Standing Other: ☐

Exercise-describe which ones: ☐

8. How would you describe the discomfort you have?
(For instance is it dull, achy, deep, sharp, constant, intermittent, etc.)

_____

9. Do you feel any numbness, tingling, or pain into your arms, hands, fingers, legs or feet?
☐ Yes ☐ No

If so, where: ☐

10. Have you had treatment for this new problem from other health practitioners? If so, who were they? _____

11. Do you have any other problems? Where in your body and for how long?

Please List: ☐

12. Since your last visit to our office have you been:

- Hospitalized, had surgery, broken any bones? Yes No

  _____

- Sprained or strained a muscle, tendon or ligament? Yes No

  _____

- Been involved in an auto accident? Yes No

  _____

- Any other personal injury or accident? Yes No

13. A) Are you currently taking any medication? If yes, what kind and dosage:

_____

_____

B) Do you currently smoke? If yes, for how long? _____

14. Do you currently take any vitamins, minerals, homeopathic or herbal remedies?

Please list: _____

_____

15. Please describe what you do during your work day. (Standing, sitting at computer, driving, lifting, hammering, etc)

If at a desk, is your computer in ☐front of you or ☐off to the side?

Is your keyboard ☐on the desk or ☐on a keyboard tray?

Do you mouse ☐left or ☐right handed?

Do you ☐ sit back into your chair, ☐lean forward or ☐ a combination of both?

Do you make use of a footstool for your feet? ☐ Yes ☐No

16. A) What is the age of your mattress?

B) Would you describe it as: ☐soft ☐medium ☐firm?

C) What is the age of your pillow?

D) Is your pillow: ☐ Flat or ☐ Contoured

E) How do you sleep?

On your: ☐Stomach ☐Back ☐Right Side ☐Left Side

17. Do you often wear: ☐ Yes ☐ No If yes, are they:

☐ Heel lifts ☐ Off the shelf store bought insoles/orthotics ☐ Custom Orthotics

How old are they?

When is the last time they were checked?

18. What are your interests and hobbies?
List as well how often, the distances or time of each sport.

19. What is your Medical Doctor's name?

20. Since your last visit has the health history of any of your family members changed?

For instance with: Neck or back problems, headaches/migraines, osteoporosis, arthritis, joint replacements, cancer, tumors, heart problems or heart conditions, strokes, asthma, allergies, diabetes.