ROCK FAMILY CHIROPRACTIC
Restoring Our City of Kingston

Dr. Anthony Donoso, D.C. & Dr. Julie Donoso, B.Sc., D.C.

File no.: _____

PERSONAL HEALTH PROFILE

Name:				Date:
Home address:		City:		Postal Code:
Email address:		Home Phone: ( )		Work Phone: ( )
Gender: M F	Marital Status: Single Married Divorced Widowed Common Law			Cell Phone: ( )
Date of Birth: MM DD YY	Age:	Occupation:		
Extended Health Insurance: Yes No Company:		$ Participation/Year:		Renewal Date:
How were you referred to our office?	Have you ever received chiropractic care before? Yes No Who was the doctor and where? # of years under care?			
Spouse's Name:	Spouse's Occupation:			
Do you have children? Yes No	What are your children's names/ages?		If under 18, parents names are?	
FEMALES ONLY If yes, how many weeks? Are you pregnant? Yes No			Is this your first pregnancy? Yes No *(please indicate)*	

PRESENT STATE OF HEALTH

Years of continuing damage show up as acute or chronic symptoms.

Is this visit for a wellness checkup? Yes No If this is for a specific concern, proceed below.

	Primary Concern	Secondary Concern
Specific concern (s) and location		
How long have you had this?		

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How would you describe the pain? dull/achy sharp pins/needles burn How often does this happen? constant daily on/off	sharp dull/achy burn pins/needles constant daily on/off
Does the pain travel? If so, where?	
At its worst, this problem interferes family/social sleep with? time hobbies work daily activities	sleep family/social hobbies time work daily activities
What makes it better?	
What makes it worse?	

If you don't get a problem corrected, do you think it will get worse in the next
1 year 2 years 5 years
Besides taking care of the above concerns, what is your greatest motive for wanting to get better/be healthier? *(eg. exercise, family, job, live longer, live easier)*

On a scale of 1 to 10 (10 being the highest), rate your commitment to improving your health (circle number)

1 2 3 4 5 6 7 8 9 10
Not committed at all
somewhat committed
Highly committed

Let's begin at birth when you may have first damaged your nervous system, lost your wellness, and began a journey to ill health. How would you describe your birth, growth, and development?

Check off the following that describe your birth.
long and/or difficult forceps vacuum extraction caesarean epidural
breech induced natural (no drugs/pulling/excessive force) don't know

As a child, were you checked regularly by a chiropractor? Yes No

TRAUMAS AND STRESSES

What are the FIVE most serious physical traumas/stresses that you've experienced (eg. Automobile jarring/impacts, work stresses, recreational activities, sports, falls, fractures...etc.)

Trauma	Date of Trauma	Office Use

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1)		
2)		
3)		
4)		

Mental/emotional stress levels (1 to 10, 10 being high):
Caused by: work family home other (please indicate)
Does your family have a history of Cancer, Diabetes, Hypertension or illness?
Have you ever been hospitalized? If so, please describe

Have you had any surgeries?
Please list any medications that you are presently or have taken in the last 5 years:

Have you had x-rays previously taken? If so, when?
Check off any of the following bodily warning signs that you have experienced in the past.

Tension/headaches Deafness/ears ringing Thyroid problems Mild back pain Earaches/ear infections Weight trouble Neck pain Low back pain Breathing problems Tension across top of shoulders Numbing/tingling in legs/feet Asthma Pain between shoulders Hip pain Immune problems Numbing/tingling in arms/hands Knee pain Frequent colds/flu Wrist/ hand pain Foot pain Heart problems Chest pain Shin splints Difficulty sleeping Heartburn Arthritis/swollen joints Anxiety/depression High/low blood pressure Allergies/infections Poor concentration/ Elevated cholesterol Digestive problems memory Poor posture Ulcer Sexual dysfunction Dizziness Diabetes Infertility Blurred/failing vision Bladder problems Cancer

Other health concerns: (**FEMALES ONLY)**
Excessive menstruation cramping/pain Hot flashes Irregular cycle