THE LIFEHOUSE

Welcome to The Lifehouse;
a Beacon of Health, Healing and Wellbeing.

Confidential Health History

Your first reservation is an opportunity for us to learn about you and your health and to ensure that your expectations and needs are addressed and met. It is also a time for you to gain new perspectives about yourself and your health.

Name _____ Today's Date: DD_____MM_____YY_____

Phone # _____ Business # _____Cell # _____

Address_____ City _____

Province_____ Postal Code _____ Email Address _____

Birth Date DD_____MM_____YY_____ BC Care Card# _____

Marital Status: Married Partnered Single Widowed Divorced

Name of Spouse/Partner: _____ Do you have children: YES / NO

How many children at home? _____Names: _____

Employer?_____What kind of work do you do?_____

Primary health advisor (ie: Name of your MD, Naturopath, Chiropractor, etc)?:_____

Have you ever been to a chiropractor before? YES / NO

If so, Dr.'s name: _____Date of last adjustment:_____

Who can we thank for referring you to The Lifehouse? _____

Is this an ICBC or WCB claim? Claim Number _____

Primary Intention

What is your main reason for seeking chiropractic care? _____

What is your main health concern/focus? _____

_____

How committed are you now, to actively participating in improving your health and wellbeing?

Not at all 1 2 3 4 5 6 7 8 9 10 100% Committed

About your Health

As the years go by and the layers of damage increase, it is common to begin to experience symptoms and random bouts of ill health until we are brought to our present state.

If you have no symptoms or complaints, and are here for wellness services, please check (√) here ____ and continue at bottom of page with **Overall Health Profile**.

Primary complaint, including when you first noticed it, and how it originally occurred.

_____

_____

If you are experiencing pain, is it:

❒ Sharp ❒ Dull ❒ Numbness ❒ Tingling ❒ Aching ❒ Burning ❒ Stabbing ❒ Radiating ❒ Stiff

Since the problem started, it is: ❒ About the Same ❒ Getting Better ❒ Getting Worse

What makes it worse? _____

How frequent is the complaint? ❒ Comes & goes ❒ Constant ❒ Daily ❒ Intermittent ❒ AM or PM _____

How long does it last? ❒ All day ❒ A Few Hours ❒ Minutes

Is there anything you can do to relieve the problem? No Yes If yes describe: _____

It Interferes with: ❒ Work ❒ Sleep ❒ Walking ❒ Sitting ❒ Exercise ❒ Leisure

If your complaint area was treated in the past, please describe treatment and results

_____

_____

Circle your level of pain: None 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Have you had any xrays taken of this area? Yes No

Overall Health Profile

Please check (√) all symptoms you have even if they do not seem related to the above problem

☐ Headaches/Migraines	☐ Depression/Anxiety	☐ Stiff Neck	☐ Hot Flashes
☐ Concussion(s)	☐ Mood Swings	☐ Neck Pain	☐ Loss of Smell
☐ Pins & Needles in Arms	☐ Irritability	☐ Back Pain	☐ Constipation/Diarrhea
☐ Dizziness	☐ Cold Sweats	☐ Loss of Taste	☐ Nervousness
☐ Loss of Balance	☐ Sensitive Eyes	☐ Cold Hands/Feet	☐ Tension
☐ Fainting	☐ Pins & Needles in Legs	☐ Fever	☐ Upset Stomach
☐ Numbness	☐ Numbness in Toes	☐ Problem Urinating	☐ Heartburn
☐ Fatigue	☐ Buzzing in Ears	☐ Menstrual Irregularity	☐ Ulcers
☐ Sleeping Problems	☐ Ringing in Ears	☐ Menstrual Pain	☐ Other: _____

Please note any major illnesses you have had: ❒ Heart disease ❒ Cancer ❒ Diabetes Other: _____

_____

Please list any major accidents or surgeries you have had: _____

_____

Please list any medications you are taking: _____

_____

_____

Stress Profile

The human body is designed to be healthy. There are many events that occur and habits that we pick up throughout our lifetime that interfere with the expression of our optimum health potential. Please take a moment now to fill out these questions so that we might better understand the layers of stress that exist in your body which are blocking your body's innate ability to heal and be healthy.

When in your life did you experience any of the stresses listed below: __ C (child), T (teenager), A (adult), N (now)

I. PHYSICAL STRESS:

					Explain
Birth Trauma	C	T	A	N	
Slips/Falls/Concussions	C	T	A	N	
Sports Injuries	C	T	A	N	
Poor Posture	C	T	A	N	
Extensive Computer Work	C	T	A	N	
Carrying Heavy Objects	C	T	A	N	
Repetitive Lifting/Bending	C	T	A	N	
Continuous Sitting/Standing	C	T	A	N	
Bone Fracture/Surgery	C	T	A	N	
Driving For Many Hours	C	T	A	N	
Car Accidents (How many? ____)	C	T	A	N	
Physical and/or Sexual Abuse	C	T	A	N	
Work Injuries (How many? ____)	C	T	A	N	
Sleeping Position/Stomach	C	T	A	N	

II. CHEMICAL STRESS:

					Explain
Smoker – Amount? _____	C	T	A	N	
Second-Hand Smoke Exposure	C	T	A	N	
Poor Diet	C	T	A	N	
Caffeine – Amount? _____	C	T	A	N	
Excessive Sugar	C	T	A	N	
Artificial Sweeteners	C	T	A	N	
Prescription Drugs	C	T	A	N	
Over-The-Counter Drugs (Tylenol, Advil, etc.)	C	T	A	N	
Recreational Drugs (Use/Exposure)	C	T	A	N	
Alcohol (Use/Abuse)	C	T	A	N	
Environmental Pollution (Air, Water, etc.)	C	T	A	N	

III. MENTAL / EMOTIONAL STRESS:

					Explain
Relationships	C	T	A	N	
Career	C	T	A	N	
Children	C	T	A	N	
Financial	C	T	A	N	
Fast-Paced Life	C	T	A	N	
Internalized Feelings	C	T	A	N	
Perfectionist	C	T	A	N	
Procrastinator	C	T	A	N	
Sickness or Loss of a Loved One	C	T	A	N	
Quick Temper	C	T	A	N	
Verbal Abuse	C	T	A	N	

IV. WHICH DO YOU FEEL IS YOUR PRIMARY STRESS? ❒ PHYSICAL ❒ CHEMICAL OR ❒ EMOTIONAL?

Explain: _____

INFORMED CONSENT

Chiropractic improves the nerve supply to your entire body and allows the Innate Healing Power of Your Body to work at maximum efficiency to restore, maintain and promote health.

Network Spinal Analysis is a light touch technique we use that consists of gentle contacts along the spine. These gentle adjustments are made at specific locations from the tip of your tailbone (coccyx) up to the top of your spine and have not been associated with any risk.

Conventional chiropractic adjustments (where a sound is heard) are also used and we would like to take the time to advise you of the risks associated with conventional chiropractic adjustments. Although rare, there is a slight chance of muscle strains, sprains and aggravation of pre-existing disc injuries. In recent years, there have also been rare reported incidents of injury to the vertebral artery during the course of neck manipulation by medical doctors, physiotherapists, as well as neck adjustments by doctors of chiropractic.

The best available evidence at this time suggests that the risk of stroke or stroke-like occurrence after a neck adjustment is 0.00025% (or 2.5 strokes/million). To put this in perspective, the risk of stroke in the general population is 0.00057% (5.7 strokes/million) which is more than double that of the chiropractic population. The risk of serious injury or death from taking aspirin or other anti-inflammatory drugs is 0.04% (400/million) and the risk of stroke from taking oral contraceptives is 0.004% (40/million).

Chiropractic care is considered to be one of the safest and most effective forms of health care. A history and examination will be performed on you to evaluate and assess for any contraindications to adjustments as well as to choose the most appropriate adjusting technique for you.

I have read and understand the information presented above. I wish to rely on the doctor to exercise judgement during the course of the procedure which the doctor feels at the time is in my best interest, based upon the facts then known to her or him. I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me by the doctor of chiropractic and/or anyone working in this clinic authorized by the doctor of chiropractic. I realize that I can withdraw my consent at any time, but at this moment, I consent to examination and care at The Lifehouse.

_____ *I authorize Dr Norman Detillieux and The Lifehouse permission to view my images/x-rays on VIHA. (please initial)*

_____ *I want to stay informed. I authorize The Lifehouse to add me to their email newsletter (please initial, you can unsubscribe at any time)*

My Reminder Preference:

_____ SMS / text _____ Email reminders _____OR Both

_____ _____ _____

Name of patient Signature of patient Date