Dr. Lori Broker

Patient Information Sheet
7 – 16 yrs.

Today's date: ______________________________

Name: ______________________________ Birth date (M/D/Y): ____________________ Age: _____

P.O. Box: ______________________________ Home phone: ______________________________

Address: ______________________________ Cell phone: ______________________________

City: ______________________________ E-mail address: ______________________________

Province: ______________________________ School: ______________________________

Postal Code: ______________________________ Care Card#: ______________________________

Physician: ______________________________

Parents: ______________________________

____

Siblings (name and age):

____

____

____

Who may we thank for referring you to our office? ______________________________

Comprehensive Health Profile

Our focus is on helping people to function optimally so that they are dynamic, healthier, better able to adapt to the stresses of everyday life, and experiencing more of the life that they want to live. This form gives us diverse insight into your health history and wellness goals.

1. What is your primary reason and/or health concern for visiting our office? ______________________________

   ____

2. Are there secondary or other reasons/concerns for your visit? ______________________________

   ____

3. Are there any other health conditions that you are experiencing? ______________________________

   ____

4. Is this an ICBC case? ______________________________

Please answer the rest of the questions with respect to your primary reason/concern.
If your answer to a question is "Yes" please explain your answer.

5. When did this begin? ____

6. Have you experienced anything like this before? ______________________________

7. Has someone in your family experienced anything like this before? ______________________

8. Since it started, is it better, worse, or the same? ______________________________

9. What makes it better? ____

10. What makes it worse? ____

11. Does it travel through your body? ____________________________________

12. Does it show up at another part of the body? __________________________

13. Have you had advice or treatment for it? _____________________________

14. Did it seem to help at the time? _________________________________

15. Since receiving treatment, has it changed? ____________________________

16. Please refer to this scale when circling how your reason/concern affects the following aspects of your life: **0-**does Not affect it **1-**slightly affects it **2-**moderately affects it **3-**drastically affects it

School	0 1 2 3	Sitting	0 1 2 3	Eating	0 1 2 3
Recreation/Play	0 1 2 3	Walking	0 1 2 3	Rest/Sleep	0 1 2 3

17. Please refer to this scale when circling your awareness of your reason/concern throughout a day:

0-not aware **1-**it comes and goes **2-**always aware **3-**drastically aware

the morning	0 1 2 3	the evening	0 1 2 3
the day	0 1 2 3	sleep	0 1 2 3

18. Is there any activity/routine during which you totally, or almost totally, forget about this reason/concern? ____

19. What have you modified (activities, movements, habits, lifestyle) since this began and how? ______
____

20. Describe how you sleep:

    a. Is it easy to fall asleep (how long)? ____________________

   b. Do you sleep deeply? ____________________
   c. What position(s) do you sleep in? ____________________
   d. How long do you sleep for? ____________________

21. If this situation were to go away tomorrow, what would be different in your life? ____________________

____

22. What do you do for exercise? ____________________

23. Do you do other activities or hobbies that interest you? ____________________

24. When you are worried or upset, how do you deal with it? ____________________

____

25. Are you aware of any prolonged, awkward, or repetitive postures/movements that you do? ________

____

26. Have you broken any bones? ____________________

27. Have you significantly strained/sprained a part of your body? ____________________

28. Have you ever injured your spine (neck, head, back, pelvis, hips)? ____________________

29. Have you ever had a concussion or been knocked unconscious? ____________________

30. Have you had any other significant accidents or injuries, vehicular or otherwise? ____________________

31. Have you had any imagery: (Please list the part of the body and when they were taken)

   a. X-rays ____________________
   b. CT's ____________________
   c. MRI's ____________________
   d. Any significant findings? ____________________
   e. Do you have the reports/films/images? ____________________

32. Have you had any surgeries? (Please list the part of the body and when it was performed) __________

____

33. Have you been hospitalised? ____________________

34. Please list any nutritional supplements (prescription or non-prescription) you have taken in last 60 days, how long you have taken them for, and the reason for taking them: ____________________

____

35. Please list any medications (prescription or non-prescription) you have taken in last 60 days, how long you have taken them for, and the reason for taking them: ____________________

____

36. Please specify the average number per day or per week of the following products (use /d or /wk):

Fruit juice ___________ Soda _____________Milk ___________ Refined sugar (candies/pastries) ________

37. Other than previously mentioned, have you consulted a physician or other healthcare provider in the past three months? ____

38. Have you been to a chiropractor before? ______________________________________

39. Have you had Network Chiropractic Care before? __________________________________

40. Is there anything else you would like to mention that has not been addressed in these forms? _______

____

____