Dr. Lori Broker
Patient Information Sheet
Adult

Today's date: _____

Patient Information

Name: _____ Birth date (M/D/Y): _____ Age: _____
P.O. Box: _____ Home phone: _____
Address: _____ Cell phone: _____
City: _____ E-mail address: _____
Province: _____ Work phone: _____
Postal Code: _____ Occupation: _____
Physician: _____ Employer: _____
Spouse: _____ Care Card #: _____
Children (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 a diverse insight into your health history and wellness goals.

1. What is your primary reason and/or health concern for visiting my 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 or Worker's compensation 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 radiate? _____

12. Does it refer to another part of the body? _____

13. Have you sought 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

Work	0 1 2 3	Social life	0 1 2 3	Eating	0 1 2 3
Exercise	0 1 2 3	Sitting	0 1 2 3	Rest/Sleep	0 1 2 3
Recreation/Play	0 1 2 3	Walking	0 1 2 3	Love life	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. How do you currently feel about your reason/concern?

- __ I feel helpless; little or nothing works
- __ I don't like what I am feeling and I hope you can fix it
- __ I feel this pattern has happened before and it is back
- __ I feel stuck
- __ I feel there is a message my body is giving me
- __ I deserve more than I have been experiencing and I would like you to assist me in my healing
- __ I am looking to enhance my quality of life, health, and wellness

23. What do you do for exercise? _____

24. Do you do other activities or hobbies that interest you? _____

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):

Alcohol _____ Drugs _____ Tobacco _____ Artificial sweeteners _____ Coffee _____
Fruit juice_____ Soda _____ Energy drinks _____ 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. Please use the following scale to grade the stress categories for their overall effect on your life:

0 - no awareness of stress 1 - slightly stressful
2 - moderately stressful 3 - extremely stressful

1) Physical stress and trauma (falls, accidents, injuries, repeated postural stress impacts, physical abuse) 0 1 2 3

2) Emotional/mental stress (loss of loved ones; rapid change in life situation; mental, emotional, sexual abuse; legal concerns; financial concerns; move of home/school/job; separation/divorce in relationship; stress of being ill? 0 1 2 3

3) Chemical stress (drugs, smoke, fumes, food additives, food choices) 0 1 2 3

41. In a published study of over 2800 patients in Network care, conducted within the Medical College at the University of California-Irvine, patients reported an overall improvement in all of the categories of health and wellness listed below. Please use this scale to rate the importance of each of the categories to you as a result of care at the office:

a – very important to me b – important to me
c – not so important to me d – does not apply to me

__ Improvement of my physical symptoms
__ Improvement of my emotional/mental symptoms
__ Improvement of my ability to react or respond to stress
__ Improvement in enjoyment of life and the ability to make constructive choices
__ Overall improved quality of life

42. Is there anything else you would like to mention that has not been addressed on these forms? _____

_____

_____

_____

_____