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First Name _____ Initial _____ Last Name _____
 Address _____ Apartment _____ Unit# _____
 City _____ Province _____ Postal Code _____
 Who Referred You To Our Clinic? _____
 Date of Birth (dd/mm/yy) _____ Male _____ Female _____ Number of children _____
 Phone: Home _____ Work _____ Cell/Pager _____
 Health Card Number _____ Version Code _____ Expiry Date _____
 Email Address _____

WHY THIS FORM IS IMPORTANT

Our office focuses on maximizing health. Our goals are to 1) address the issue that brought you to this office and 2) to offer the opportunity to learn and improve health potential for the future. Daily activities/stresses/traumas can accumulate and cause damage to your nervous system. This damage builds layer upon layer to a level at which you may not yet be aware. We need to know what your layers of damage contain, so we ask you to carefully fill out this detailed and IMPORTANT FORM.

THE BEGINNING YEARS OF LIFE (Birth to Age 15)

Research is showing that many of the health challenges that occur later in life originate during the developmental (early) years of our lives. That's why many parents bring their children in for regular spinal check-ups – so that they can be as healthy as possible and prevent future problems. Please be specific as you can with your answers.

	YES	NO	COMMENTS:
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you fallen/jumped from a height over three feet? (crib/bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there any prolonged use of medicine, such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any other traumas? (physical or emotional)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you Vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you under regular chiropractic care as a child?	<input type="checkbox"/>	<input type="checkbox"/>	_____

YOUNG ADULT (Age 15 to Present)

Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>	_____
On a scale of 1-10 describe your stress level at Work _____ Personal Life _____ (0=None 10=Extreme)			
On a scale of Poor, Good, Excellent describe your: Exercise _____ Sleep _____ Diet _____			

Have you ever been to a Doctor of Chiropractic before? Who? _____
When? _____ For what reason? _____

Patient Name: _____

Date: _____

People who have already experienced Chiropractic Wellness Care and are here to continue, need only check the box "Wish to continue my Chiropractic Maintenance" .

Others need to briefly describe what activities your problem prevents you from doing, either partially or totally. This problem interferes with: Sleep Walking Sitting Leisure Work (What is your job? _____)
Explain: _____

The following symptoms are signs of nervous system dysfunction. Please mark all that you presently have or have had in the past even if they do not seem to be related to your current problem.

O – occasional F – frequent C – constant

- | O F C | O F C | O F C |
|---|--|---|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pins & Needles in arms | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Visual problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Problems urinating |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menstrual pain |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergies |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of balance | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cold hands | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cold feet | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of taste | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Stomach tension |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irritability | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of smell | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Mood swings | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Depression | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck pain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sweating |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Back pain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds/sickness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness |

Who is your family Doctor? _____ Phone: _____

Please list any medications that you are currently taking: (including aspirin, Tylenol, antihistamines, birth control pills, HRT, etc...) _____

Health conditions of family members:

Children: _____

Immediate family: _____

Are there any other details that you would like the doctor to know? _____

Do you utilize other forms of Holistic health care methods? (Massage Therapy, Naturopathy, Yoga, Acupuncture, Vitamins, Herbs...) _____

What Vitamins / Herbs do you take? Please list _____

Do you sleep with a special cervical pillow? _____

Do you use orthotic shoe devices? _____

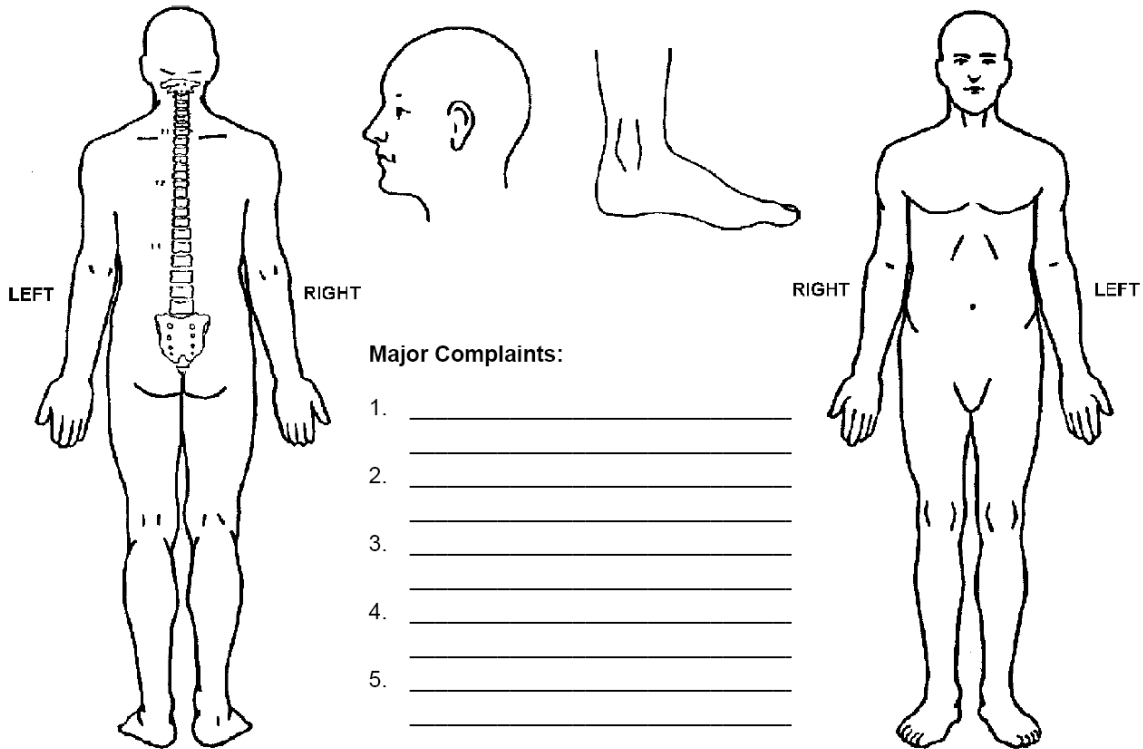
Do you suffer from any of the following:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Heart condition / Angina | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Intestinal tract disorder |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tendonitis / Bursitis | <input type="checkbox"/> Hormonal imbalances | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Prostate Condition | <input type="checkbox"/> Spinal Disc Problems | <input type="checkbox"/> PMS | <input type="checkbox"/> Bloating after meals |
| <input type="checkbox"/> Weak Immune System | <input type="checkbox"/> Lack Of Energy | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Eczema / Psoriasis |

This page must be filled out by the patient !
Please fill in every line on this page with pertinent information.

Patient Name: _____ **Date:** _____

* In the section of **Major Complaints**, please list them in order of severity. Next to the #1 write down the **main concern** you have right now (ex. Headaches). Next to #2,3,4,5 indicate any other problems you are experiencing (ex. Left Knee pain, etc...)



Major Complaints:

1. _____
2. _____
3. _____
4. _____
5. _____

N – Numbness P- Pain T – Tingling A – Ache S – Soreness ST – Stiffness

Please use the above chart to draw the letter “X” in the areas that bother you. Next to each of these areas, use the appropriate letter to describe what you feel. (Example: If your left hand is numb, draw an “X” in the left hand and put “N” next to the this hand for Numbness).

Is this a new problem or have you had it in the past? _____

How long have you had this problem? _____

How did the pain begin? (Did you fall, just wake up with it...) _____

What makes it better? (Heat, Ice, Certain positions...) _____

When does it bother you most and what makes it worse? (Sitting, Day/Night, etc..) _____

Is it constant or does it come and go? _____

Is the pain localized or does it travel into other areas? _____

Have you seen anyone else about this problem? Who _____ When _____

If yes, what was their diagnosis? _____

Have you had previous treatment for this problem? What kind? _____ When _____

Have you had any surgeries? (Describe which and why) _____

Have you ever been diagnosed with any diseases? (Cancer, MS, Diabetes, etc..) _____

Has your problem caused any other problems (digestive, sight, hearing...) _____

Have you lost more than 20lbs in the past 90 days? _____