Personal Information

Name_____ Date_____

Address_____ City_____

Province _____ Postal Code _____ Date of Birth D ___ M ___ Y _____ Age _____

Home Phone _____ Cell Phone _____ Email _____

Where do you prefer to be contacted? Home____ Work ____ Cell ____

Business/Employer _____ Business Ph. _____ Ext. _____

Type of work _____

Marital Status: Single / Married / Partner / Divorced / Widow Spouse's Name _____

Do you have children? Y N Names/Ages of children: _____

Are you pregnant? Y N Weeks _____

Whom may we thank for referring you to The Lifehouse?

We highly recommend subscribing to our email list to receive our monthly newsletter plus information about events and promotions. Would you like to be added to our list ☐***Y*** ☐***N***

Check the phrase(s) that most represent your approach to your health & lifestyle:

I make choices based on: __Crisis/symptoms __Improving health, lifestyle & quality of life
__Preventing problems __ Doing whatever it takes to be at my best

Health Concerns *(If there are no current concerns and this assessment is to ensure optimal health and functioning, skip to the next page)*

Concern	Severity 1= mild 10= worst	When did it start? For how long?	If you had the condition before, when?	Did the problem begin with an injury?	What % of the time is the symptom present?

Is this condition interfering with your:

□Work □Family □Sleep □Daily Routine □Sports/Activities □Quality of Life

Other: _____

What other health practitioners have you seen? (mark P for past or C for current)

□ Chiropractor □ Medical Doctor □ Naturopath □ Physiotherapist □ Massage Therapist

□ Other: _____

Where are you now?

1 ----------50----------100

(Symptoms) *(Optimal Health)*

Where would you like to be? (1-100) ___ How long do you think it would take to get there? _____

Please circle: Do you feel your daily choices are moving you away from or towards health & wellbeing?

What is your level of commitment to yourself, your life and wellbeing? 0=Low 10=High

I would rate the overall movement and flexibility in my neck 10 = flexible 0 = rigid	
I would rate the overall movement and flexibility in my mid back 10 = flexible 0 = rigid	
I would rate the overall movement and flexibility in my low back 10 = flexible 0 = rigid	
I am able to notice tension and release it in my body. 10 = completely notice tension & release it 0 = not at all	
My overall posture & ease in standing straight 10 = great 0 = terrible	
I sleep deep & wake up feeling rested 10 = rested 0 = tired	
I feel I have energy for all my daily activities 10 = a lot 0 = none	
I have effective strategies to deal with emotional stress 10 = excellent 0 = none	
My stress levels are: 10 = extremely high 0 = virtually none	
My diet is 10 = excellent 0 = terrible	
My exercise is 10 = excellent 0 = none	
My immune system is strong. (I am rarely ill, and recover quickly.) 10 = yes 0 = no	
My balance and co-ordination is good 10 = yes 0 = no	
I have good focus, concentration, memory & creativity 10 = yes 0 = no	
My breathing is good. (I am rarely short of breath or have asthma.) 10 = yes 0 = no	
My digestive system is working well. (I rarely feel gassy or bloated, or have heart burn, and have regular daily bowel movements.) 10 = yes 0 = no	
My reproductive/hormonal health is good. (I have minimal symptoms like PMS, menopausal issues, and have a healthy sex drive.) 10 = yes 0 = no N/A	
I feel emotions like anger, depression, unhappiness, hopelessness, or feeling 'stuck'. 10 = daily 0 = rarely	
I feel emotions like joy, happiness, gratitude, hope 10 = daily 0 = rarely	
I have balance in my life and a high level of life enjoyment 10 = yes 0 = no	

Physical History

Birth Stress – Do you have any information about your birth history: □ Yes □ No

Was your birth □ drug induced □ forceps or suction □ breech
□ "C" section □ cord around the neck □ natural
□ prolonged □ other: _____

Infant Health: □ Colicky □ Repeated infections □ Childhood illness □ Hospitalization
□ Other _____

General Physical Trauma:

Please list any childhood falls/accidents

Type: _____ Age: _____ Hospitalized? Y N
Type: _____ Age: _____ Hospitalized? Y N
Type: _____ Age: _____ Hospitalized? Y N

Please list any accidents or injuries: Auto, work related, sports or other:

Type: _____ Age: _____ Hospitalized? Y N
Type: _____ Age: _____ Hospitalized? Y N
Type: _____ Age: _____ Hospitalized? Y N

Surgeries:

Type: _____ Date: _____ Reason: _____
Type: _____ Date: _____ Reason: _____
Type: _____ Date: _____ Reason: _____

During the day I: □ Sit □ Stand □ Walk □ Do desk work □ Phone work
□ Drive □ Do mechanical work □ Heavy lifting

Sports and Leisure:

I exercise: □ Daily □ Weekly □ Monthly
□ Walking □ Biking □ Running □ Swimming □ Yoga □ Strength training
□ Aerobic classes □ Other _____

Hours per week watching TV? 0-10 10-20 20-30 30-40
Hours per week on the computer? 0-10 10-20 20-30 30-40

Biochemical History

Please list ALL drugs you currently take or have taken in the past 6 months:

Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N

Please list all nutritional supplements, vitamins or homeopathic remedies you currently take:

Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N
Name: _____ Reason: _____ Prescribed? Y N

Nutritional Choices

Please grade any dietary selection that is appropriate for you using the following scale:

FD – I consume this a few times per day
FW – I consume this a few times per week
FM – I consume this a few times per month
O – I do not consume this
D – I consume this once per day
W – I consume this once a week
M – I consume this monthly

____ Alcohol
____ Tobacco
____ Coffee
____ Breads, pastas
____ Diet foods
____ Dairy (milk products)
____ Refined sugar
____ Artificial sweeteners
____ Soft drinks
____ Fast food
____ Processed/packaged

The type of diet I usually follow is classified as: _____

General Emotional Trauma:

With each of the following potentially stressful situations, please mark either 'P' for past or 'C' for current.

	Mild	Moderate	Extreme		Mild	Moderate	Extreme
Childhood stress	____	____	____	Change in vocation	____	____	____
School stress	____	____	____	Financial stress	____	____	____
Family stress	____	____	____	Change in lifestyle	____	____	____
Personal relationships	____	____	____	Stress of being sick	____	____	____
Work related stress	____	____	____	Abuse	____	____	____

Please check any of the stress coping techniques you currently use:

□ Exercise □ Nature □ Deep breathing □ Yoga □ Meditation □ Reading
□ Prayer □ Music □ Counselling □ Life coach □ Bodywork
□ Other _____

Commitments

How do you grade your physical health?

□ Excellent □ Good □ Fair □ Poor □ Getting better □ Getting worse

How do you grade your biochemical health?

□ Excellent □ Good □ Fair □ Poor □ Getting better □ Getting worse

How do you grade your psychological/emotional health?

□ Excellent □ Good □ Fair □ Poor □ Getting better □ Getting worse

In addition to your main reason for your visit today, what additional health goals do you have for your future?

_____

_____

Is there anything else you would like to bring to our attention?

_____

_____