Unit 5,72 Charing Cross Street, Brantford, Ontario, N3R 7S1 Tel: 519.754.0183 Fax: 519.754.1431
Stacey J. Cooper-Latimer B.Sc.(H.K.), D.C., F.I.C.P.A

PERSONAL HEALTH PROFILE

Date:	Last Name:	First Name:	Email Address:
Home Address:		City:	Postal Code:
Home Phone: ( )		Work Phone: ( )	Cell Phone: ( )
Gender: ❒ M ▫ F	Height (feet, inches):	Weight (pounds):	Marital Status: ▫Single ▫Married ▫ Common law
Date of Birth: MM DD YY	Age:	Occupation:	Employer:
Work address:		City:	Postal Code:
Extended Health Insurance: ▫ No ▫ Yes Company:		$ Participation / Year:	Renewal Date (i.e. Jan 1):
How were you referred to our office?		Have you ever received chiropractic care before? ▫ No ▫ Yes Date of last visit? Who was the Doctor? Years under care? Where was the Doctor?	
Spouse's Name:		Spouse's Occupation:	
Do you have children? ▫ No ▫ Yes	What are your children's names/ages?	If you are under 18, what are your Parents' names?	
Family Medical Doctor's Name:		City:	

	Primary concern	Secondary concern
Specific concern(s) and location		
How long have you had this?		
How would you describe the pain?	❒ sharp ❒ dull/achy ❒ burn ❒ pins/needles ❒Other:________________	❒ sharp ❒ dull/achy ❒ burn ❒ pins/needles ❒ Other:________________
How often does this happen?	❒ constant ❒ on/off ❒ daily	❒ constant ❒ on/off
What makes it worse? (sitting, standing etc)		
What have you tried to address this concern?		
At its worst, this problem interferes with:	❒ ability to work ❒ hobbies/sports ❒ family/social time ❒ sleep ❒ daily activities ❒Other:________________	❒ ability to work ❒ hobbies/sports ❒ family/social time ❒ sleep ❒ daily activities ❒Other:________________

Cooper Chiropractic Centre

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What are the most important reasons you want better health ____

____

On a scale of 1 to 10 (10 being the highest), rate your commitment to improving your health *(circle number):*

1 2 3 4 5 6 7 8 9 10

Not committed — Somewhat committed — Highly committed

Let's begin at birth when you may have first damaged your nervous system, lost your wellness and began a journey to ill health.

Birth, Growth and Development

Child birth has been proven to be traumatic to the spine and nervous system. How was your birth?
❒ Long and/or difficult ❒ Forceps ❒ Vacuum extraction ❒ Caesarean ❒ Breech ❒ Epidural ❒ Induced
❒ Vaginal ❒ Natural (no drugs or pulling/excessive force) ❒ Don't know?

Did you get checked regularly by a chiropractor as a child? ❒ yes ❒ no

Traumas and Stresses

In your whole life, what were your 5 most serious physical, mental or chemical trauma/stresses (eg. automobile jarring/ impacts, work posture/activities, recreational activities, sports, falls, fractures, work/personal stresses)

Trauma	Date of trauma	Office use	
1)		❒ ya ❒ yo	❒ Checked
2)		❒ ya ❒ yo	❒ Checked
3)		❒ ya ❒ yo	❒ Checked
4)		❒ ya ❒ yo	❒ Checked
5)		❒ ya ❒ yo	❒ Checked

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What did you like the MOST about your previous experience with your Doctor of Chiropractic/Medical Doctor?

____

____

If you don't get the problem corrected do you think it will get worse in the next ❒ 1 year ❒ 2 years ❒ 5 years

Mental/Emotional stress levels (1 → 10, 10 being high): _____ Caused by ❒ work ❒ home ❒ family ❒ other

____

Have you ever been hospitalized? If so, please describe

____

What surgeries have you had?

____

What medications/chemicals are you currently taking? ____

____

____

What medications/chemicals have you taken in the last 5 years?

____

____

Family Health History

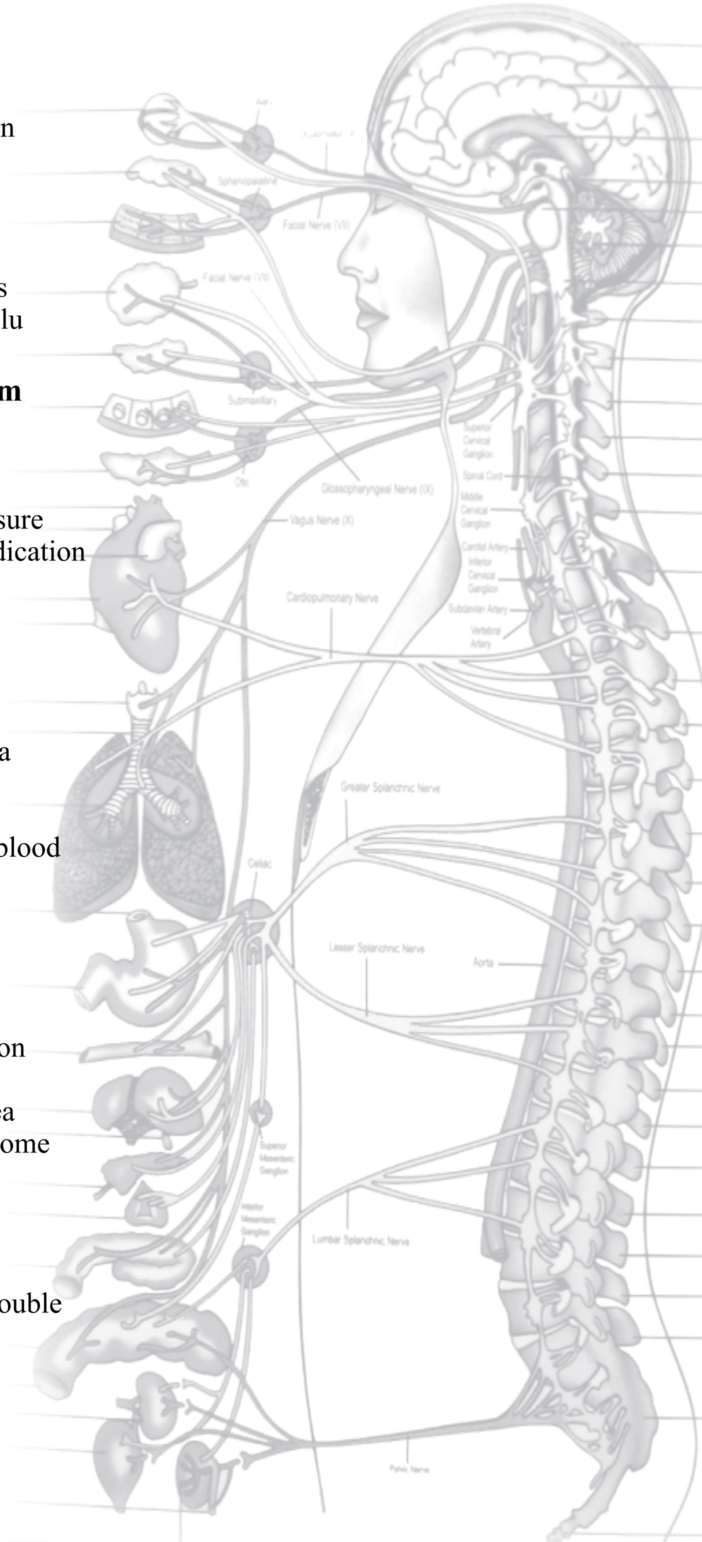
Many health concerns are related through family members. What health concerns has your family experienced?

Children:________________________ Spouse/Partner:_____________________ Parents:______________________

Health Concerns

Please check/circle any of the following signs of organ malfunction or disease you have experienced

☑ CURRENT
(EXPERIENCED BEFORE)



Immune System
❑ Earaches/ear infection
❑ Sore throat/tonsilitis
❑ Sinus problems
❑ Autoimmune disease
❑ Antibiotic use
❑ Fever / chills / sweats
❑ Frequent colds and Flu

Cardiovascular System
❑ Chest pain
❑ Shortness of breath
❑ Heart medication
❑ High/low blood pressure
❑ High cholesterol medication
❑ Swelling of legs
❑ Heart problems

Respiratory System
❑ Frequent bronchitis
❑ History of pneumonia
❑ Asthma/allergies
❑ Chronic cough
❑ Spitting up phlegm /blood
❑ Difficulty breathing
❑ Tuberculosis
❑ Pneumonia

Digestive System
❑ Heartburn / indigestion
❑ Stomach cramps
❑ Constipation /diarrhea
❑ Irritable bowel syndrome
❑ Crohn’s disease
❑ Ulcers
❑ Belching /gas
❑ Nausea or vomiting
❑ Liver /gall bladder trouble
❑ Colon trouble
❑ Black /bloody stool
❑ Diabetes

General Symptoms
❑ Dizziness
❑ Blurred /failing vision
❑ Deafness /ringing in ears
❑ Thyroid problems
❑ Fainting / dizziness
❑ Seizures / convulsions
❑ Skin problems
❑ Tremors
❑ Loss of balance
❑ Unexplained weight loss/gain
❑ Anemia
❑ Alcoholism
❑ HIV/AIDS
❑ Loss of sleep/difficulty sleeping
❑ Poor memory /concentration
❑ Learning disability
❑ Irritable /nervous /tension
❑ Anxiety/ depression
❑ Decreased energy / fatigue
❑ Tired /lethargic
❑ Cancer: __________________
❑ Weight trouble
❑ Sexual dysfunction/Infertility

Musculoskeletal System
❑ Headaches: tension /migraine
❑ Neck pain /stiffness
❑ Tension across shoulders
❑ Pain between shoulders /stiffness
❑ Numbness /tingling: hands /arms
❑ Wrist/hand pain
❑ Scoliosis / spinal curvature
❑ Hip pain
❑ Iliotibial band syndrome
❑ Low back pain / stiffness
❑ Numbness/tingling in legs/feet
❑ Poor posture
❑ Painful tailbone
❑ Foot trouble, L R
❑ Knee pain
❑ Foot pain
❑ Shin splints
❑ Bladder problems
❑ Arthritis/swelling

Females Only
❑ Painful menstruation
❑ Irregular cycle
❑ Excessive /irregular flow
❑ Excessive cramping/pain
❑ Abnormal discharge
❑ Hot flashes
❑ Past menopause
❑ Miscarriages #_______
❑ Breast pain/lumps
❑ Infertility
❑ Currently pregnant? Y or N
❑ Date of last menstrual period: ___ /___ /___