Your Health

Welcome to Health Connection, specialists in your health and well-being. Our primary goal is to diagnose the problems that brought you here, and secondly to offer you the opportunity to improve your health in it's entirety, now and for the future.

In our daily life, we encounter various stresses physically, biochemically and psychologically/emotionally that accumulate and create a reduction in our potential health. Many times, these effects are so gradual that they cannot be felt until they have become more complicated problems. Your responses to the following questions will give us a profile of problems, past and present, and will help us understand your case and develope a plan most adequate for your situation.

1. Personal Information

Date:___/___/____ Name: _____

I would like to be called: Mr(s) ☐ Dr ☐ First name ☐ Other:_____

Date of Birth: ___/___/____ Financial Contribution Number: _____

Address:_____

Zip Code/Postal Code: _____ City/Location: _____

Civil Status: _____ Number of children:_____

Profession: _____Employer:_____ Work Phone:_____

Home Phone:_____ Mobile Phone:_____

I prefer to be contacted: Home ☐ Mobile ☐ Work ☐ No preference ☐

Email:_____

May we contact you via email? Yes ☐ No ☐

Who can we thank for referring you to our clinic?_____

2. Health Profile

Symptoms:

What is the reason for this consultation: Pain ☐ Check-up ☐ Maintenance ☐ Prevention ☐

What are your objectives? Temporairily relieve pain ☐

Correction of the problem (time is an important factor) ☐

Indicate on the figure the principle problem areas using the legend below:

Acute (A)

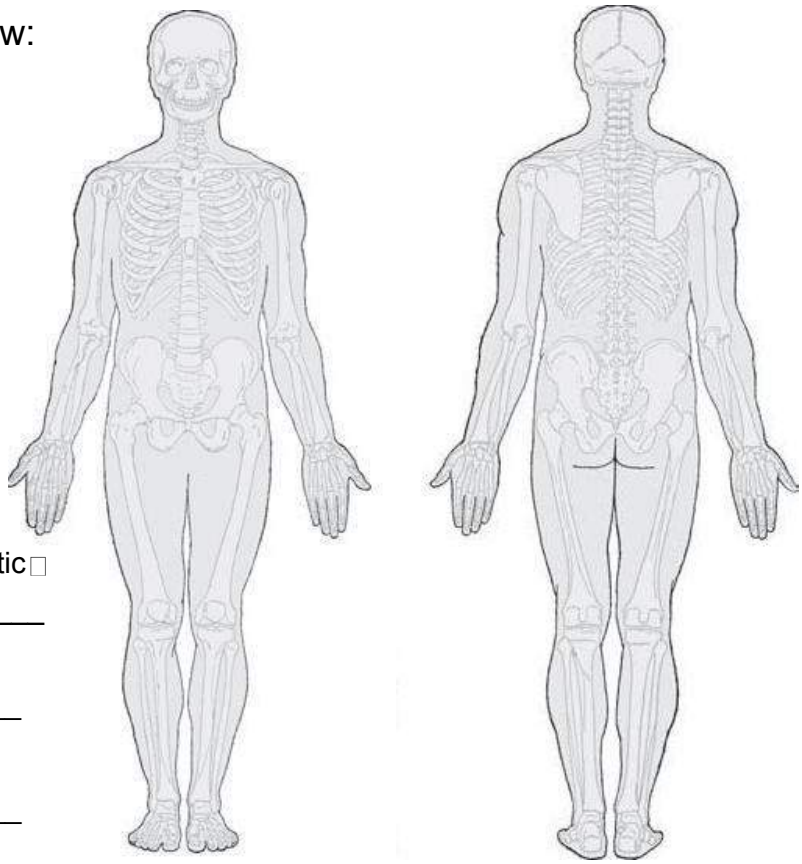
Numbness (N)

Tingling (T)

Dull (D)

Deep (P)

Tension (T)



Type of Pain:

The pain is: Constant ☐ Comes and goes ☐ Erratic ☐

Frequency: (10%-100% of the time)?_____

What makes the pain worse?

_____

What reduces the pain?

_____

Has this problem been seen by someone? Who?_____What was the diagnosis?_____

The problem is: Better ☐ Worse ☐ The same ☐

When and how did the symptoms appear?_____

_____

Mark in the following columns, on a scale of 0 (none) to 10 (unbearable) the level of your pain.

Frequent	Occasional	**Problem**
		Headache
		Migraines
		Neck pain
		Pain in the arm/hand
		Middle back pain
		Lumbar pain
		Herniated discs
		Arthritis/Arthroses
		Skin problems
		Dizziness
		Nausea
		Nervousness
		Lethargy
		Sleep problems
		Numbness
		Tingling
		Scoliosis
		Sciatica

Frequent	Occasional	**Problem**
		Osteoporosis
		Colds
		Ringing in ears
		Otitis
		Digestive problems
		Constipation
		Allergies
		Asthma
		Menstrual problems
		Infertility
		Urinary tract problems
		Respritory problems
		Neurological problems
		Anxiety
		Hypertension
		Irritability
		Hyperactivity
		Other:

Indicate 2 or 3 things that are the most important to you and that you have difficulty doing because of this problem.

_____ , _____ , _____