

ascension wellness centre

Namaste / Nei Ho / Ahalan / Buna / Bonjour / Xin Chao / Jambo / Hola / Salve / Vitayu / Sa-wat-dee / Kon-nichiwa / An-nyong Ha-se-yo / Guten Tag / Parev / Ahoj / Gia'sou / Hei / Shalom / J6 napot / Dzien dobry / Vitayu / Merhaba

Name: _____ Date: _____

Address: _____ Postal code: _____

Telephone: Home _____ Work _____ Cell _____

Email Address: _____ Birthdate (M/D/Y): _____

Age: _____ Weight: _____ Height: _____

Alberta Health Care number: _____

Occupation: _____ Employer: _____

Marital Status: Single Married Divorced Separated Widow Cohabiting

Full time student: Y/N, if so where?

Children: Name: _____ Name: _____

Age: _____ Age: _____

How did you find out about Ascension Wellness Centre?

Who referred you to Ascension Wellness Centre?

Is this a medical legal case? If so, name of lawyer?

Did the injury happen at work?

Client Health Information

Present area of concern:

Your symptoms are (circle): increasing not changing decreasing

Have you had any previous treatment for this condition?

When did this begin? _____

What makes your problem better?

What makes your problem worse?

What is the purpose of this appointment? _____

What type of care you desire (circle)? [Acute] [Temporary relief]

[Corrective care] [Preventative care/

Wellness]

Name of family physician: _____

Names of specialists currently consulting:

List all medications you are presently taking?

List all supplements/vitamins you are presently taking?

List any allergies: _____

Please check any of these professionals you have seen previously and the approx date of your last visit? Chiropractor: _____ Acupuncturist:

_____ Naturopath: _____

ART provider: _____ Shiatsu practitioner: _____ Massage therapist:

Have you been treated for any health condition in the last year?

If so, please explain: _____

List all major surgeries or operations and when they occurred:

List Major Accidents or falls?

Please **circle** any conditions which are **presently causing you any problems**

Please underline any that have bothered you in the past.

General

Whiplash Enlarged glands Loss of weight Hypoglycemia
Vision problems Hearing problems Frequent colds/flu's

Body Systems

Frequent urination Painful urination Blood in urine Kidney stones
Prostate problems Anemia Hypothyroid Hyperthyroid
Gas/Bloating Constipation Diarrhea Colitis Black/bloody stool
Hemorrhoids Liver trouble Gall bladder trouble Eczema Psoriasis
Varicose veins Asthma Shortness of breath Heart problems.

Musculoskeletal System

Low back pain Neck pain Arm pain Shoulder pain Elbow pain
Wrist pain Leg pain Knee pain Foot pain Pain/numbness down arms or
legs Painful tailbone Pain between the shoulders Scoliosis
Arthritis
Walking problems Difficulty chewing Clicking jaw Ankle
swelling

Nervous System

Vertigo Dizziness Fainting Headaches Ringing in the Ears
Loss of feeling Confusion Depression

Circle any that you have experienced:

Alcoholism Epilepsy Stroke Arthritis Hypoglycemia Tuberculosis
Rheumatic fever Diabetes Cancer Allergies Heart disease
High blood pressure Osteoporosis.

Has anyone in your family had any of the following?

Heart disease Cancer High blood pressure Stroke Arthritis
Diabetes

How many times per week do you exercise?

How many hours of sleep do you get per night? Do you feel it is enough?

How much coffee do you drink? _____ How much tea do you drink?

How much alcohol do you consume (circle) ? None Light Moderate Heavy

How much tobacco do you consume (circle)? None Light Moderate Heavy

How stressed are you (circle)? None Light Moderate Heavy

What are your health goals?

How many glasses of water do you drink per day? _____