FOR OFFICE USE ONLY:

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JES	WED	THURS
GUEST		

220 Wexford Road, Unit 2 Brampton, ON L6Z 4N7 (905) 840-WELL

- ☐ Dr. Justine Blainey-Broker, B.Sc., D.C.
- ☐ Dr. Blake Broker, B.Sc, D.C.
- ☐ Dr. Steve Gillis, BPE, ART, D.C.
- ☐ Dr. Stephanie Behmer, D.C.
- ☐ Other

Confidential Teen (Ages 11-17) Case History

		DI
CE		
SUB		
X-RAY C/SP		
X-RAY T/SP		
X-RAY L/SP		
X-RAY OTHER		
GAIT		
TOTAL		

Name: ______________________ Age: __________ Today's Date: _____________

Address: ____

Residence and Mailing City Province/State Postal Code/Zip

Home Telephone Number: ____________________

Work Telephone Number: ____________________ Cell Phone Number:____________

Email: _________________________ Birth date:________________ Male: __ Female:__

Occupation: ____

Number of siblings: _____ Parents names: _________________________________

Have you had previous chiropractic care? (circle one) Yes No

Chiropractor's name: ____

Medical Doctor's name and phone number: ____

Who may we thank for referring you to our office? ____

Reason for Consulting our Office:

____

Your Health Profile

Why This Form Is Important

On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	YES	NO	UNSURE
Did you have any serious falls?	☐	☐	☐
Do you play youth sports?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree)	☐	☐	☐
Were you involved in any car accidents	☐	☐	☐

	YES	NO	UNSURE
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas? (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

	YES	NO
Do/did you smoke?	☐	☐
Do/did you drink alcohol?	☐	☐

On a scale of 1-10 describe your stress level: (1 = none, 10 =extreme) School: _____Personal: _____

On a scale of 1-10, rate yourself on the following with 1 being poor and 10 being excellent:

Diet: ___/10 Exercise: ___/10 Sleep: ___/10 Mental Clarity/Focus: ___/10 General Health: ___/10

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Wellness Check up: Circle: Yes No

Specific Concerns:____

____

If you are experiencing pain, is it:

☐ Sharp ☐ Dull ☐ Numbness ☐ Tingling ☐ Aching ☐ Burning ☐ Stabbing ☐ Radiating

Since the problem started, it is: ☐ About the Same ☐ Getting Better ☐ Getting Worse

What makes it worse? ____

How frequent is the complaint? ☐ Constant ☐ Daily ☐ Intermittent ☐ Night Only

How long does it last? ☐ All day ☐ A Few Hours ☐ Minutes

Is there anything you can do to relieve the problem? ☐ Yes ☐ No If yes describe: ________________________

It Interferes with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

0 1 2 3 4 5 6 7 8 9 10

Please mark an X on the line above to indicate your problem level

Please check (√) all symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ ns & Needles in Legs	☐ Fainting	☐ Neck Pain
☐ Pins & Needles in Arms	☐ Loss of Smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Buzzing in Ears	☐ Ringing in Ears	☐ Nervousness
☐ Numbness in Fingers	☐ Numbness in Toes	☐ Loss of Taste	☐ Upset Stomach
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping Problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Sensitive Eyes	☐ Problem Urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcer

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

	NAME(S):	Condition(s):
Sister(s):		
Mother:		
Father:		
Brother(s):		
Others:		

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Stress Test

When in your life did you experience any of the stresses listed below: C (child), T (teenager), N (not at all)

I. PHYSICAL STRESS:

				Explain
Birth Trauma	C	T	N	
Slips/Falls	C	T	N	
Sports Injuries	C	T	N	
Poor Posture	C	T	N	
Extensive Computer Work	C	T	N	
Carrying Heavy Objects	C	T	N	
Repetitive Lifting/Bending	C	T	N	
Continuous Sitting/Standing	C	T	N	
Bone Fracture/Surgery	C	T	N	
Driving For Many Hours	C	T	N	
Car Accidents (How many? ____)	C	T	N	
Physical Abuse	C	T	N	
Work Injuries (How many? ____)	C	T	N	
Sleeping Position/Stomach	C	T	N	

II. CHEMICAL STRESS:

				Explain
Smoker – Amount? _____	C	T	N	
Second-Hand Smoke	C	T	N	
Over-The-Counter Drugs (Tylenol, Advil)	C	T	N	
Environmental Pollution (Air, water, etc)__	C	T	N	

III. EMOTIONAL STRESS:

				Explain
Internalized Feelings	C	T	N	
Perfectionist	C	T	N	
Procrastinator	C	T	N	
Sickness or Loss of a Loved One	C	T	N	
Quick Temper	C	T	N	
Verbal Abuse	C	T	N	

IV. WHICH DO YOU FEEL IS YOUR PRIMARY STRESS? ☐ PHYSICAL ☐ CHEMICAL OR ☐ EMOTIONAL?

Explain:

____

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NOTE TO PATIENT: We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you. If you have any questions, please ask.

I, ________________________________

- have read the below statement and consent to examination and if appropriate, treatment:

Physicians, Chiropractors, Osteopaths, and Physiotherapists are required to advise patients with neck problems of the following: There have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes or strokes like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, with or without x-rays, have been performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions and other conditions.
I understand all accounts are payable when service is rendered.

- Consent to all encompassing chiropractic treatments knowing the Doctor (s) will discuss ahead of time them with me. (Example: Orthotics, change of techniques etc.)

- Consent to seeing another JBWC Doctor if/when needed. (Example: Time restrictions, scheduling, acute condition needing help and my primary Doctor is away etc.)

- I understand that to provide me with health goods and services, the Justine Blainey Wellness Centre will collect some personal information about me (e.g., home telephone number, address).

I understand that the Justine Blainey Wellness Centre has a Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information.

I understand that I may receive the following: newsletters, Thank you cards, Birthday cards, phone calls, health packages etc. that may be of interest to me.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to the Justine Blainey Wellness Centre collecting, using, and disclosing personal information about me as set above and in the Justine Blainey Wellness Centre's Privacy Policy.

I hereby authorize the release of my medical/chiropractic records or copies of the same to such parties that the doctor may deem necessary as it relates to my case, and do hereby hold harmless anyone from such actions.

Signature of Patient: ____

Witness: ____

Date: ____