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## **Personal Health Profile**

| Name:                         |  | Referred By:   |   |  |  |
|-------------------------------|--|--|---|--|--|
| Address:                      |  | City:  | Fel: or MFC to email appointment reminder   |  |  |
| Postal Code:                  | Home Tel:  | Cell 7   | Геl:  |  |  |
| Age: Birthdate                | e: (D)/(M)/(   | (Y) Is it ok for   | or MFC to email appointment reminders   |  |  |
| Email:                        |  | and new  | sletters?   |  |  |
| Marital Status: M S W         | V D C Spouse's Nam   | e:   | # of Children:  |  |  |
|                               | ABOU   | Γ YOUR HEALTH  |   |  |  |
| history will uncover the laye | rs of damage, especially to you outline a course of care to be | our nervous system, that hat egin to correct these layers of | age your health expression. This case ve resulted in poor health. Following your of damage and recover your innate health |  |  |
| Erom hirth cortain strasses i |  | ody Health (Birth to Pres                                    |   |  |  |
|                               | ns and random bouts of sicknown                                |  | ne and nervous system. Eventually you   |  |  |
| oegin to experience sympton   |  | dhood History  |   |  |  |
| Childhood Surgarias           |  |  |   |  |  |
| Cilifullood Surgeries         |  |  |   |  |  |
| Childhood injuries, falls     | , car accidents:   |  |   |  |  |
| Contact Sports:               |  |  |   |  |  |
| Concussions: □No □Uns         | sure □Yes When/How man   | у  |   |  |  |
|                               | After Ch   | aildhood to present  |   |  |  |
| Workplace:                    |  | Occupation:  |   |  |  |
|                               |  |  |   |  |  |
| -                             |  |  |   |  |  |
| Car Accidents: When?_         |  |  |   |  |  |
|                               |  |  |   |  |  |
| E-11-/Lui-sui-su              |  |  | XVII  |  |  |
| rans/injuries:                |  |  |   |  |  |
|                               |  |  | When:   |  |  |
| T' C M !'                     |  |  | When:   |  |  |
| List of Medications:          | 2)   | 2  |   |  |  |
|                               | 2)   |  |   |  |  |
| 3)                            | 4)   | 5) _   |   |  |  |

Many times symptoms indicate a long standing spinal condition. Please check off any symptoms you experience now, or have experienced in the past.

| <u>Cervical</u> |                | <u>Thoracic</u>   |               |                 |                                    |  |  |
|-----------------|----------------|---|---------------|-----------------|------------------------------------|--|--|
| <u>Past</u>     | <u>Present</u> |   | <u>Past</u>   | <u>Present</u>  |                                    |  |  |
|                 |                | Headaches   |               |                 | Mid Back Pain                      |  |  |
|                 |                | Migraines   |               |                 | Chest Pain                         |  |  |
|                 |                | Fatigue/ Insomnia/Difficulty                                |               |                 | Heart Problems                     |  |  |
|                 |                | Irritability/ Anxiety/Depression                            |               |                 | Heartburn                          |  |  |
|                 |                | Neck Pain   |               |                 | Difficulty Breathing/Asthma        |  |  |
|                 |                | Dizziness   |               |                 | Ulcers                             |  |  |
|                 |                | Nausea  |               |                 | Forearm/elbow pain □ Left □ Right  |  |  |
|                 |                | Loss of Concentration                                       |               |                 | Shoulder Pain □ Left □ Righ        |  |  |
|                 |                | Arm pain/numbness □ Left □                                  |               |                 |                                    |  |  |
|                 |                | Hand pain/numbness □ Left □                                 |               |                 |                                    |  |  |
|                 |                | Thyroid Issues  |               |                 |                                    |  |  |
|                 |                | Cough   | <u>Lumbar</u> |                 |                                    |  |  |
|                 |                | Vision Problems   | <u>Past</u>   | <b>Present</b>  |                                    |  |  |
|                 |                | Ringing in Ears   |               |                 | Digestive Problems                 |  |  |
|                 |                | Earaches  |               |                 | Low Back Pain                      |  |  |
|                 |                | Hearing Loss  |               |                 | Constipation                       |  |  |
|                 |                | Allergies   |               |                 | Diarrhea                           |  |  |
|                 |                |   |               |                 | Urinary Problems                   |  |  |
| <u>Genera</u>   | <u>al</u>      |   |               |                 | Menstrual Problems                 |  |  |
| <u>Past</u>     | <b>Present</b> |   |               |                 | Diabetes                           |  |  |
|                 |                | Arthritis   |               |                 | Disc Degeneration                  |  |  |
|                 |                | Fibromyalgia  |               |                 | Hip Pain □ Left □ Right            |  |  |
|                 |                | Cancer  |               |                 | Leg pain/numbness □ Left □ Right   |  |  |
|                 |                | Osteoporosis  |               |                 | Knee pain □ Left □ Right           |  |  |
|                 |                | High Blood Pressure   |               |                 | Ankle pain □ Left □ Right          |  |  |
|                 |                | Weight Problems   |               |                 | Foot/Heel/Arch pain □ Left □ Right |  |  |
|                 |                |   |               |                 | Wear Orthotics?                    |  |  |
| Please desc     | cribe your sy  | mptoms or areas of concern with yo                          | ur health:    |                 |                                    |  |  |
| Please mar      | k the intensi  | ty of your pain/discomfort on the sca                       | ale below:    | :               |                                    |  |  |
| 0 (no pain      | at all)        | 5   |               | <br>10 (worst r | oain imaginable)                   |  |  |
| How long l      | have you had   | d this condition?Have                                       | you had a     | similar co      | ndition in the past?               |  |  |
|                 |                | toms have been getting:   better                            |               |                 |                                    |  |  |
| •               |                | □ dull □ burning □ tight □                                  |               |                 | h 🗆 tingling?                      |  |  |
| -               | -              |   |               | _               |                                    |  |  |
|                 |                | ering with your:  work home                                 |               | -               |                                    |  |  |
|                 | =              | seen about this condition?                                  |               |                 |                                    |  |  |
| -               |                | practor before? □ yes □ no Wl<br>any visits?Reason for disc |               |                 |                                    |  |  |
| Approxima       | attra now ma   | any visits:Keason for disc                                  | onunung       | carc            |                                    |  |  |
| For women       | ı: As x-rays n | nay be taken, is there a chance you may                     | y be pregn    | ant? Yes _      | No Please Initial:                 |  |  |