vitalinformation

NA11

Complete the following to help us serve you. Please Print. Today's Date _____

1 Vital Information

First Name _____ Last Name _____

Birthday M _____ D _____ Y _____ Gender _____

Address _____

City _____ Province _____ Postal Code _____

Email _____ Website _____

Home Tel. _____ Priority ____ △ Leave Message Work Tel. _____ Priority ____ △ Leave Message

Cellular _____ Priority ____ △ Leave Message Employer Name _____

How did you find out about Vital Elements? _____

Your primary interest at Vital Elements? △ Integrated, vitalistic approach to wellbeing and healing for you and your family
△ Chiropractic Services △ Naturopathic Services

Other Comments and/or Concerns?

2 Important Contacts

Emergency Contact _____ Telephone _____ △ Leave Message

Relationship _____

Medical Doctor _____ Telephone _____

Address

3 Living Situation

Marital Status △ Single △ Married (How Long?) △ Common Law (How Long?) △ Widowed (How Long?) △ Divorced (How Long?)

Please list immediate family members - spouse, partner, children (same or different address) - and/or others living at the same address.

First Name	Last Name	Age	Relationship	Same Address?
				△
				△
				△
				△
				△

vitalconcerns

NA12

4 Current Health Concerns

*What is your reason for seeking our services?*_____

_____

What concerns do you have about your health and well being? Please list in order of importance.

_____

Please answer the following questions with respect to your most important concern.

*In what part of your body do you experience your pain/symptoms?*_____

Does your pain/symptom travel to anywhere else in your body? Y ☐ N ☐

*If Yes, where?*_____

What does this pain/symptom feel like? Please check any that apply:

Sharp ☐ *Stabbing* ☐ *Dull* ☐ *Achy* ☐ *Numbness* ☐ *Tingling* ☐ *Burning* ☐

Cold ☐ *Pins & Needles* ☐ *Electricity* ☐ *Other (specify):* _____

When did this pain/symptom begin? _____

*What happened?*_____

How has the pain/symptom changed over time? *Worse* ☐ *Better* ☐ *No Change* ☐

How often does this pain/symptom occur? _____

*When your pain/symptom is present, how long does it last?*_____

On the scale below, please mark the level of pain you most consistently feel, with 0 being no pain and 10 being the worst pain you can imagine.

1 ——————————————— 10

*What makes this pain/symptom better?*_____

*What makes this pain/symptom worse?*_____

Are there any other related or associated concerns? _____

Have you ever experienced this pain/symptom or something similar in the past? Y ☐ N ☐

If Yes, please describe: _____

Have you sought advice or treatment from a health professional? Y ☐ N ☐

If Yes, what were you told? _____

*What was done?*_____

Did it seem to work? Y ☐ N ☐

Other comments/concerns?

vitalhistory

NA13

5 Previous Chiropractic

Is there anything about your Nerve System and Spine that we should know about? _____

_____

What are your concerns? _____

Have you been to a Chiropractor before? Y ☐ N ☐ *If Yes, when, why did you go, what was done, what did you enjoy about your experience?* _____

_____

6 History of Life Stresses

Please indicate any of these that apply to you.

Show past stressors by underlining, show current ones by circling .

Traumatic Events

Slips Falls Car Accidents Injury Broken Bones/Fractures Surgeries Sprains Contact Sports

Repetitive Stressors

Lifting Bending Carrying Computer work Standing/Sitting for long periods Long drives

Chemical Stressors

Smoking 2nd Hand Smoke Vaccinations OTC Drugs Recreational Drugs Alcohol Caffeine Refined Sugar Artificial Sweeteners Occupational Environmental Substance Abuse

Mental/Emotional Stressors

Relationships Family Children/Dependants Emotional/Sexual Abuse Divorce/Separation Loss of loved One Change in Residence Change in Career Work School Fast-paced Life Internalized Feelings Quick Temper Perfectionist Procrastinator Financial Illness

Birth History

Home ☐ *Hospital* ☐ *Forceps* ☐ *Caesarean Section* ☐

Other Trauma / Complications:

7 Medical History

Date and reason for last visit to medical doctor (symptoms, diagnosis, treatment, outcome): _____

_____

Please list any current medications/supplements that you are currently taking: _____

_____

Please list any medications used in the past for more than three months and their purpose: _____

_____

Have you or anyone in your extended biological family had any previous significant health issues? (i.e. heart disease/stroke, cancer, diabetes, infections) ? Please describe: _____

vitalexperience

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8 Wellness & Lifestyle

How do you feel when you first wake up in the morning? How do you begin your day?	Experience of Vitality Δ Great Δ okay Δ dissatisfied Alertness and Clarity Δ Great Δ okay Δ dissatisfied
What is the quality and quantity of your sleep and rest?	Level of Energy Δ Great Δ okay Δ dissatisfied Ability to Fall Asleep Δ Great Δ okay Δ dissatisfied
Yesterday, what did you choose to eat for Breakfast? Lunch? Snack? Dinner?	Mental Focus and Concentration Δ Great Δ okay Δ dissatisfied Weight and Body Image Δ Great Δ okay Δ dissatisfied Digestive Function Δ Great Δ okay Δ dissatisfied
What is your daily fluid intake?	Bowel Movement and Urination Δ Great Δ okay Δ dissatisfied
How much/what physical activity do you get? Are you training?	Balance, Coordination Δ Great Δ okay Δ dissatisfied Physical Flexibility Δ Great Δ okay Δ dissatisfied
What type of work do you do, activities and responsibilities?	Physical Endurance Δ Great Δ okay Δ dissatisfied Physical Strength Δ Great Δ okay Δ dissatisfied
What do you do for play and relaxation?	Time for Self Δ Great Δ okay Δ dissatisfied
When was your last vacation?	Work and Career Δ Great Δ okay Δ dissatisfied
What is your future vision for yourself?	Financial Situation Δ Great Δ okay Δ dissatisfied
What is the quality of your human relationships? Any pets?	Connectedness with Others Δ Great Δ okay Δ dissatisfied Intimate Relationship(s) Δ Great Δ okay Δ dissatisfied
When stressed, how do you "centre" yourself or "re-group"?	
Is there some aspect of your life that very much pleases you, brings you joy or helps you to feel good about yourself?	

On a scale of 1(low) to 10(high), please rate the following.	Resourcefullness	Current Life Stress	Level of Health	Overall Life Happiness

vitalobjectives

NA15

What is your present motivation for consulting our office?

☐ *Heal disease, symptoms and infirmities*

☐ *Preventing disease, symptoms and infirmities*

☐ *Improving family and/or community health*

☐ *Maximizing personal health potentials*

9 Your Needs and Hopes for Care

In a published study of over 2,800 participants in Network Spinal Analysis, the participants reported an overall improvement in several categories of health and wellness listed below.

Please indicate how you hope to benefit from care in this office:

	Definitely	***Would be Nice***	***Unimportant***
Improvement of physical symptoms	☐	☐	☐
Improvement of emotional/mental symptoms	☐	☐	☐
Improvement of my ability to react/respond to stress	☐	☐	☐
Improvement in enjoyment of life	☐	☐	☐
Ability to make constructive choices	☐	☐	☐
Overall improved quality of life	☐	☐	☐

10 Understanding Where You're At

What is your commitment to yourself, your life and well-being on a scale of 1 to 10, where 1 is no commitment and 10 is "will do whatever it takes"? _____

Are there particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook etc. that you feel may impair your opportunity for full vitality and health? _____

_____

Are there any factors and elements mentioned above that you feel give you an edge or add to your health? _____

Is there anything else that may help in understanding you, your history or your professional needs which have not been discussed on this survey? _____

_____

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vitalconsent

NA16

Consent to Chiropractic Assessment and Care at Vital Elements

It is our commitment to you that you are fully informed about the services that we offer at Vital Elements Chiropractic and that you understand any possible benefits or risks to the care that you receive. At Vital Elements, the delivery of the Chiropractic Adjustment involves multiple types of force application. Type 1 consists of gentle contacts along the spine, and/or gentle body contacts and body movements. Type 2 consists of a faster, and deeper force that may or may not result in the release of a sound. Other procedures employed in this office include interviews, physical and tonal assessments, digital photo imaging, and other physiological assessment instruments.

In all healthcare professions, informed consent is required where the client is informed of benefits and risks of service. Here we agree to provide Adjustments, the client agrees to receive Adjustments, and there may be risk associated with Adjustment. There may be risk, particularly with Type 2 force applications. Possibilities include injury to muscle (strain/sprain), disc, bone, and blood vessels (stroke). To date, no valid scientific data exist which causally relate injury to vessels and the Chiropractic Adjustment[1]. The Chiropractic Adjustment represents less force to the vertebral artery than common activities of daily living[2] (ie, turning the head within normal range of motion). Available Chiropractic literature estimates a correlational value of 0.00025% (2.5 strokes/million) cervical adjustments being associated with stroke[3]. To put this in perspective, the risk of stroke in the general population is 0.00057% (5.7 strokes/million), which is more than double that of the Chiropractic population[4]. The risk of serious injury or death form taking aspirin or other anti-inflammatory drugs is 0.04% (400/million) and the risk of stroke from taking oral contraceptives is 0.004% (40/million)[5]. Chiropractic care is considered to be one of the safest and most effective forms of health care.

Although rare, some people experience an increase in current pain or symptoms while most do not. As the Adjustment releases more Life into the body we cannot predict what the Intelligence of the body will create. It is important to note that an increase in symptoms, although uncomfortable, may signify a positive adaptive strategy of your body.

I, _____ the undersigned have completely read and understood the above statements and consent to Chiropractic Adjustments and Procedures being performed on me by the Chiropractor and/or anyone working at Vital Elements authorized by the Chiropractor. I have had the opportunity to discuss with the Chiropractor any questions or concerns I may have. I also understand that results are not guaranteed, and that my consent can be withdrawn or modified at any time I choose.

Signature _____ *Date* _____

Signature of parent or Guardian (for anyone under the age of 18) _____ *Date* _____

Witness _____ *Date* _____