CONFIDENTIAL PERSONAL HISTORY QUESTIONNAIRE DATE: _____

NAME: (First) _____ Last_____ M____F___

Birthday (Mo/day/yr) _____ Age _____ Occupation_____

Mail Address_____City/Town_____Province_____Postal_____

e-mail _____Phone (h)_____Work phone (W)_____

MSP PREMIUM ASSISTANCE _____IF yes, PIN #_____

EXTENDED HEALTH: Yes ___no____ ICBC: claim# _____WCB_____

HOW DID YOU HEAR ABOUT DR. ZALESKI? _____

REASON FOR YOUR VISIT: _____Health and wellbeing _____Specific complaint

Provide details: _____

Please check (x) all symptoms you are experiencing even if they seem unrelated to your concern:

___headache ___ pins & needles in legs ____ or arms ___fainting ___ neck pain ___stiff neck

___loss of smell __ Back pain __loss of balance __dizziness __buzzing in ears __nervousness

__numbness in fingers __or toes __loss of taste __stomach upset __fatigue __depression

__irritability __tension __sleeping problems __cold hands __cold feet __fever __hot flashes

__cold sweats __diarrhea __constipation __lights bother eyes __problem urinating __ulcers

__heartburn __mood swings __menstrual pain __menstrual irregularity

PREVIOUS CHIROPRACTIC CARE ? _____When & How often_____

CHECK ANY PRACTICES BELOW THAT YOU HAVE EXPLORED:

Massage/other body work_____ Reiki/ other energy work_____ yoga_____ Chi Gong_____

Acupuncture/Chinese medicine_____Cranial/sacral Work_____Physio_____

Nutritional counseling_____Meditation_____ counselling_____ Other_____

Do you realize that your present condition could be caused by a nervous system that is "preloaded" w/ physical, emotional, and/or chemical stress accumulated over time? This is known as a vertebral subluxation. Subluxations are caused by any stress our body/mind cannot properly perceive, adapt to, or recover from. Keep this in mind when answering the following questions.

BIRTH STRESS: (*check which applies*)

I was born at Home_____ Birthing centre _____ Hospital_____ other_____

I was incubated_____ isolated after birth_____nursed _____ bottlefed_____

My birth involved: Trauma_____Drug induced_____"C"section_____Breech_____Natural_____

Forcepts/suction_____ cord around neck_____ prolonged labor_____other_____

My mother was taking drugs or alcohol/tobacco during pregnancy_____ill _____

Difficult pregnancy_____accidents_____Other_____

PAST INJURIES

Have you had any car/bike accidents: No_____ yes_____When:_____

Have you had any serious injuries: No_____yes____When:_____

Have you had any broken bones No____yes_____when:_____

Have you had major surgery/procedures: No____yes_____When:_____

"CHEMICAL" STRESS (ingestion, exposure, anything taken into body**) N**: *never* **M***: moderate* **E**: *excess*

Worked with chemical fumes, dust, smoke, toxin for prolonged periods_____

Environmentally sensitive_____allergies_____

Prescription drugs_____Alcohol_____Marijuana_____drugs_____

Tobacco_____caffeine_____artifical sweeteners_____soda-pop_____sugar_____

Fried food_____processed foods_____meat_____fish_____dairy_____

Fresh veggies_____organic_____fast_____other_____

PHYSICAL ACTIVITY: *(indicate if past or current*)

Active in sports_____what and how often_____sports injuries_____

Exercise regularly_____prolonged sitting_____prolonged standing_____

Prolonged driving_____mechanical work_____heavy lifting_____

Prolonged reading_____computer_____musical instrument_____

EMOTIONAL HISTORY / STRESSES: Include severity **S** (slight**), M** (moderate**), E** (extreme)

Childhood stress_____school stress_____family stress_____

personal relationships_____being sick_____work stress_____financial_____

personal tragedy_____loss of loved one_____

change in lifestyle/vocation_____abuse_____

other information you would like us to know about you_____

The statements made on this form are accurate to the best of my recollection

_____signature date_____