Tri-City Wellness Centre Inc.
53 Ainslie Street North
Cambridge, ON N1R 3J6
(519) 267-8855
www.tri-citywellness.ca
georgina@tri-citywellness.ca

Date: _____

Name: _____ Blood Type: _____

Main Health Goals: _____

General Health Status: _____

Date of Birth: _____ Birth Place: _____

Mailing Address: _____

_____

_____

Telephone: _____ Home

_____ Work

_____ Cell

Please * telephone preference for appointment reminders.

E-mail Address: _____

Primary Care Physician: _____ Phone: _____

Who may we thank for recommending you to our clinic?

_____

Tri-City Wellness Centre Inc. respects your rights to privacy. This information will remain on your file and will be accessed solely as a resource for your personal treatment and for the purpose of confirming your appointments. If any other situation arises, your consent will be sought prior.

Current Medications (please list ALL medications you are taking):

Prescriptions/OTC □ no □ yes Explain _____

Supplements (herbs, vitamins, minerals) □ no □ yes Explain _____

What is your average daily water consumption: Amount: _____ Type/Quality of water: _____

Do you drink alcohol? □ no □ yes Weekly Average: _____

Weekly consumption of other beverages? ____Coffee ____Tea ____Soft Drinks ___Other

Do you smoke? □ no □ yes Daily Average _____

Allergies:

Seasonal (pollen, hay fever) □ no □ yes □ mild □ moderate □ severe

Other (sensitivities, anaphylaxis, etc.) □ no □ yes Explain _____

Medication Required □ no □ yes Explain _____

Special Diet (low-fat, gluten-free, etc.) □ no □ yes Explain _____

Specific food cravings? □ no □ yes Explain _____

Sleep posture: □ side □ back □ stomach

Number of hours sleep per night _____hours

Quality of sleep (e.g., unbroken, refreshing): Explain _____

Sleep environment (e.g., quiet, peaceful, 100% darkness): _____

Did/do you wear braces on your teeth? □ no □ yes # months/years _____

Did/do you wear a dental appliance? □ no □ yes Explain _____

Did/do you have mercury dental amalgam? □ no □ yes Explain _____

Surgery/hospitalizations? □ no □ yes Explain _____

Accidents/injuries? □ no □ yes Explain _____

Change in weight (greater than 10lbs/4.5kg in the last six months) □ no □ yes

Regular exercise program □ no □ yes Explain _____

All Current and Past Conditions
Check box if applicable; CIRCLE specific conditions
C = current; P = past

MUSCLES/JOINTS/NERVES

C P

Head and Neck

- □ □ headaches/migraines
- □ □ neck pain/whiplash/injury
- □ □ (head/neck) tingling/numbness
- □ □ tooth/jaw/ear pain/TMJ
- □ □ vision condition(s)
- □ □ hearing condition(s)/dizziness
- □ □ head trauma/concussion
- □ □ loss of coordination

Trunk

- □ □ back pain/injury/scoliosis
- □ □ degenerative/herniated discs
- □ □ hip pain/sciatica

Arms/Hands/Legs/Feet

- □ □ pain/tingling
- □ □ weakness/numbness
- □ □ fractures/strains/sprains
- □ □ tendonitis/fibrositis/bursitis
- □ □ osteo/rheumatoid arthritis
- □ □ muscle/nerve disease

SKIN

- □ □ lack of sensation/numbness
- □ □ irritated condition/frostbite
- □ □ skin infection/disease

HEART/CIRCULATION

C P

- □ □ high/low blood pressure
- □ □ chest pain/angina
- □ □ heart attack/stroke
- □ □ heart disease
- □ □ pacemaker
- □ □ bruise easily
- □ □ swelling (chronic)
- □ □ phlebitis/thrombosis

LUNGS/RESPIRATION

- □ □ sinus problems
- □ □ shortness of breath
- □ □ chronic cough
- □ □ asthma/bronchitis
- □ □ emphysema

DIGESTION/UROGENITAL

- □ □ digestive problems/heartburn
- □ □ nausea/bloating/gas (chronic)
- □ □ constipation/diarrhea (chronic)
- □ □ IBS/colitis/Crohn's
- □ □ ulcer/hernia
- □ □ liver/gall bladder disease
- □ □ urinary infection/disease
- □ □ kidney infection/disease

GENERAL/SYSTEMIC

C P

- □ □ anxiety/stress
- □ □ unresolved emotions
- □ □ fatigue/insomnia
- □ □ eating disorder
- □ □ drug/alcohol issues
- □ □ fibromyalgia/chronic fatigue
- □ □ osteoarthritis/osteoporosis
- □ □ inflammatory arthritis
- □ □ diabetes
- □ □ undiagnosed lump
- □ □ cancer
- □ □ epilepsy
- □ □ TB/hepatitis/HIV
- □ □ internal pins/wires
- □ □ artificial joints

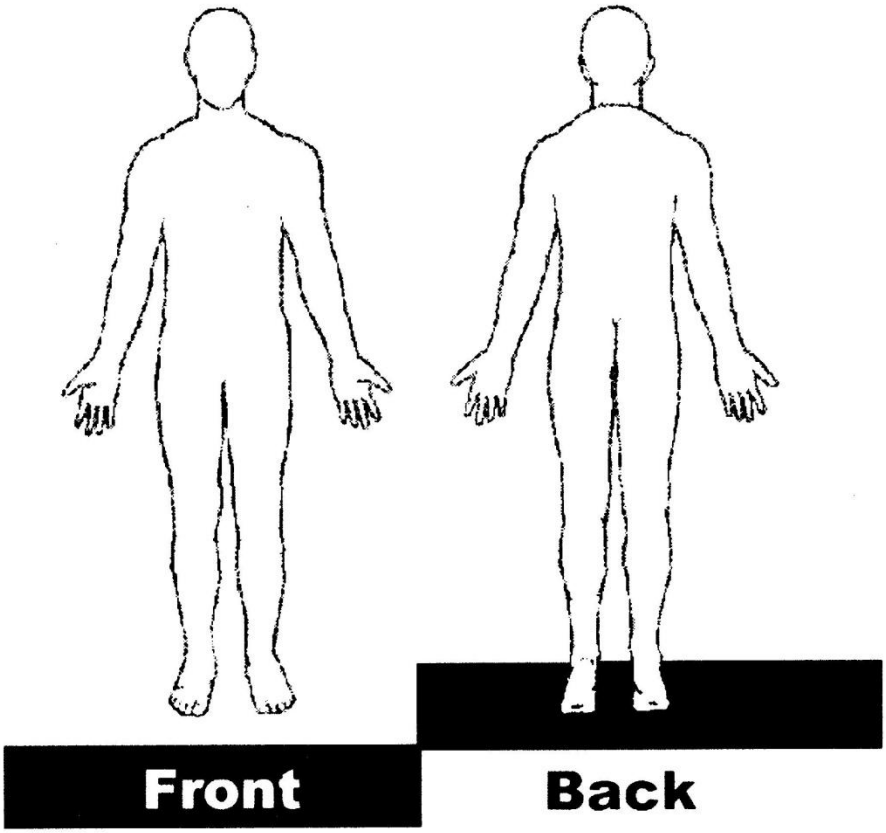
WOMEN

- □ □ menstrual changes/problems
- □ □ endometriosis
- □ □ other gynecological conditions
- □ □ menopausal complications
- □ □ pregnant - due: _____
- □ □ other

MEN

- □ □ prostate problem
- □ □ other _____

Please CIRCLE areas of **pain/discomfort** in your body on the following diagrams:



Prior treatment for present condition(s). Check all that apply.

_____	Chiropractic Adjustment	_____	Surgery
_____	Massage	_____	Cranial Sacral Therapy
_____	Osteopathy	_____	Facial Massage
_____	Physiotherapy	_____	Regimen (Diet, Exercise Plan, etc.)
_____	Reiki	_____	Hydrotherapy
_____	Bowen Therapy	_____	Hypnotherapy
_____	Herbs	_____	Prescription Medication
_____	Other	_____	None of the Above

Any other relevant information you would like to share about your past/present physical or mental condition(s): _____

_____

_____

_____

How did you hear about Tri-City Wellness Centre and/or Georgina Hanchar? _____

_____

_____

_____

Patient Consent Form

Privacy of your personal information is an important part of our clinic, while providing you with quality care. We understand the importance of protecting your personal information. This clinic will collect, use and disclose information about you for the following purposes: to assess your health concerns, to advise you of treatment options, to establish and maintain contact with you, to send you a newsletter and other information mailings, to remind you of upcoming appointments, and to complete claims for insurance purposes.

I have read and understood the above consent for myself and/or my child.

Signature: _____ Date: _____

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Guide to Developing a Sequential Time Line

Note: Please organize all shocks and traumas in a chronological sequence.

Consider the following as possible shocks:

Physical

- Pre-birth: any drugs, alcohol, smoking or severe illnesses in mother (particularly of a viral nature); also consider any emotional shocks to mother during pregnancy or in mother/father at time of conception (see section on emotional traumas below); ultrasound or other invasive testing.
- Birth: Mother had difficult labour; forceps used; use of anaesthetics on mother; late breathing or other possible oxygen deprivation.
- Vaccinations: Dates, if possible of initial vaccination of each kind received (can usually ignore booster shots).
- Accidents: car accidents, falls, blows to head, concussions, broken bones.
- Surgical interventions: Tonsils, appendix, adenoids, dental, abdominal (including Caesarean sections); circumcision, vasectomy, hysterectomy.
- Drug use: antibiotics, anti-depressants, recreational drugs, etc.
- Hormones: birth control pill, hormone replacement therapy.
- Severe Infections: Lyme disease, mononucleosis, Epstein-Barr, measles, chicken pox, mumps, TD, pneumonia, etc.
- Electrical shocks: including medical treatment.

Mental

- Traumas involving **loss, abandonment, grief, betrayal** (e.g., death, loss of trust, relationship breakups, loss of independence, job loss).
- Traumas involving great **fear/anxiety**.
- Traumas involving **anger and indignation/humiliation** (particularly where the emotion was suppressed/"swallowed").
- Feelings of **guilt, envy** or **jealousy**.
- Traumas involving **abuse**, whether mental, emotional or sexual.

Note: Some emotional traumas can involve a combination of emotions. See reverse side for sample time line.

Sample Time Line

- 2002 August – Laid off from work, period of high stress – headaches began
- 2001 January – Severe bronchitis – 4 weeks in bed, antibiotic use, exhaustion
- 1998 March – Mom died of cancer – very sudden diagnosis, shock, grief, anger
- 1993 February – Broke left leg skiing
- 1990 June – Break-up of serious relationship – many months of sadness
- 1985 October – Hep B vaccine
- 1979 May – Family in car accident – not serious – bumps and bruises, shock
- 1975 September – Family dog died – first experience of death, sadness
- 1972 July – MMR vaccine – original
- 1971 November – DPT vaccine – original
- 1970 January – Birth – mom was induced; antibiotic drops in eyes; born blue – cord wrapped around neck
- Pre-birth – at 7 months mom fell down flight of stairs – no injury, but very anxious for baby