# Your Life Review –

**Box 1**

**NAME:** _____ **DOB:** _____

**Box 2**

**Please take a moment to complete the following health questionnaire.**

**Please check all your neurological warning signs even if not seemingly related to your complaint.**

| OVER AROUSED NS | UNDER AROUSED NS | UNSTABLE NS | EXHAUSTED NS |
|---|---|---|---|
| Frequent colds | ADD or ADHD | Headaches | Fevers |
| Anxiety | Hypoglycemia | Seizures | Fatigue |
| Cold hands/feet | Poor concentration | Narcolepsy | MS |
| Ulcers | Worried | PMS | Epstein-Barr syndrome |
| Bowel problems | Irritability | Sleep walking | Fibromyalgia |
| Restless sleep | Low energy | Hot flashes | Depression |
| Nervousness | Easily distracted | Allergies | Rheumatoid arthritis |
| High Blood Pressure | Disorganization | Bipolar disorders | Chronic fatigue syndrome |
| Tight muscles | Incontinence | Eating disorders | Auto-immune system disorders |
| Accelerated aging | Constipation | Bed wetting | |
| Heart palpations | Difficulty awakening | Mood swings | |
| Poor expressions of emotions | Low pain threshold | Panic attacks | |

**How about your spouse and children, can you find them on this chart? YES NO** _____

**Box 3** **History**

**LIST ALL CURRENT MEDICATIONS and DRUGS:**_____

_____

**HOSPITAL BIRTH: YES NO Were there any complications with your birth? YES NO** _____

_____

**INJURIES? YES NO** _____

**BONE FRACTURES?** _____ **DID YOU FALL AS A CHILD? YES NO** _____

**EVER BEEN KNOCKED OUT? YES NO** _____ **EVER FAINT? YES NO** _____

**SURGERIES?** _____

_____

**MOTOR VEHICLE ACCIDENTS? (please note type and year, even if not apparently injured) YES NO**

**LIST DATES and INJURIES 1)**_____ **2)**_____

**3)** **4)**

**Box 4** **Bio-Chemical Trauma**

**1) Have you ever taken antibiotics? YES NO For what conditions?** _____

_____

**2) In your lifetime, have you taken antibiotics more than 5 times? Yes No How many times**_____

**3) Do you use recreational drugs? YES NO Which one(s)?**_____

## Box 5 ALL EMOTIONS ARE PHYSICAL AND MANIFEST IN YOUR SPINE AND POSTURE

**With each of the following stress situations, please check either None, "P" for past or "C' for current.**

| | NONE | MILD P | MILD C | MODERATE P | MODERATE C | EXTREME P | EXTREME C | COMMENTS |
|---|---|---|---|---|---|---|---|---|
| Childhood stress | | | | | | | | |
| School Stress | | | | | | | | |
| Play or recreational | | | | | | | | |
| Family stress | | | | | | | | |
| Personal relationships | | | | | | | | |
| Loss of loved one | | | | | | | | |

Father__Mother__Spouse__Partner__Child__Sibling__Relative__Friend_

| | | | | | | |
|---|---|---|---|---|---|---|
| Change in lifestyle | | | | | | |
| Change in vocation | | | | | | |
| Abuse | | | | | | Was this: Physical__ Emotional__ Sexual __ |
| Stress of being sick | | | | | | |
| Work related stress | | | | | | |

## Box 6 Past Healing Experiences

**1) Have you had experience with the following health oriented systems?**

| | Yes | No | Results Good | Bad | ?? | Comments |
|---|---|---|---|---|---|---|
| • Massage | | | | | | |
| • Counseling/Psychotherapy | | | | | | |
| • Yoga/Pilates | | | | | | |
| • Dance | | | | | | |
| • Homeopathy/Herbalist | | | | | | |
| • Ayurvedic Medicine | | | | | | |
| • Oriental Medicine/Acupuncture | | | | | | |
| • Nutritional Therapy | | | | | | |
| • Special Diet | | | | | | |
| • Weight Training/Body Building | | | | | | |
| • Rebirthing/Breath work | | | | | | |
| • Tai Chi/Chi Gong | | | | | | |
| • Meditation/Contemplation | | | | | | |
| • Prayer | | | | | | |

- Medicine_____
- Chiropractic_____

Other: _____

**2) When stressed, how do you "center yourself" or "regroup"? _____**

_____

**Box 7** **Diet and Nutrition**

**1) Please circle any dietary selection that is appropriate for you, and grade according to the following scale:**

**0 - Do not consume this**
**M –Consume this monthly**
**FM - Consume a few times per month (less than weekly)**
**FD - Consume this a few times per day**
**W - Consume this weekly**
**FW - Consume this a few times per week**
**D - Consume this daily**

| | | | |
|---|---|---|---|
| Alcohol ___ | Diet Food ___ | Whole Grains ___ | Fish ___ |
| Coffee ___ | Refined Sugar ___ | Dairy (milk products) ___ | Seafood ___ |
| Tobacco ___ | Eggs ___ | Fried Foods ___ | Weight Control Diet ___ |
| Artificial Sweeteners ___ | Vegetables ___ | Beef ___ | Fasting ___ |
| Soda ___ | Fruits ___ | Poultry___ | Organic Foods ___ |

**Do you skip meals? YES NO If yes, which meal? Breakfast Lunch Dinner**

**What do you usually eat for breakfast?** _____

**The type of diet I usually follow is classified as:** _____

**Please list the nutritional supplements you take daily.** _____

_____

**Box 8** **Your Specific Hopes and Needs in this Office**

**Please use this scale for questions 1 & 2**

**A – very important to me** **B – important to me**
**C – not so important to me** **D – does not apply**

1. **Of the following five choices, which is currently of most interest to you and how do you hope to benefit from care in this office?** In a published study of over 2800 patients under Network Chiropractic care, conducted within the Medical College at the University of California Irvine, patients reported improvement in all of the categories of health and wellness listed below.

_____ **Improvement in my physical symptoms**
_____ **Improvement of emotional/mental symptoms**
_____ **Improvement of my ability to react or respond to stress**
_____ **Improvement in enjoyment of life and ability to make constructive choices**
_____ **Overall improved quality of life**

**What do you do for your personal physical fitness?** _____

_____

**Is there anything else you may wish to share which may help us to better understand you?** _____

_____

**What would motivate you to tell others about the care you receive in this office, and encourage you to refer new patients to this office for care?** _____

_____

_____

**Box 9** **Financial Agreement**

**I understand that I am personally and completely responsible for any and all fees that I incur against my account at Dr. H. Marcoux's Chiropractic Office. I understand that all fees are due at the time services are rendered unless a fully paid prepayment plan is in place. I also understand that fees billed to Manitoba Health (MHS), Non-Insured Health Benefits, MPI, and WCB that are NOT honored for any reason whatsoever are my complete responsibility and are due upon official notification of refusal of payment by the third party agency.**

**I understand that I am responsible for submitting billing to my Health Insurance Company and that Dr. H. Marcoux's Chiropractic Office does not submit bills on my behalf.**

**All fees and charges have been explained to me in full.**

**SIGNED BY ME IN WINNIPEG, MANITOBA ON _____, 20____**

**PRINT NAME_____ SIGNATURE_____**

**WITNESS_____ DATE_____**