



**Dr. Stacy Larsen**  
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**YOUR CREATING WELLNESS ASSESSMENT**

**PERSONAL INFORMATION**

Date \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Cell # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Occupation \_\_\_\_\_ Office phone \_\_\_\_\_ E-mail \_\_\_\_\_  
 Birthdate M/ \_\_\_ D/ \_\_\_ Y/ \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed \_\_\_ How many children? \_\_\_\_\_  
 Whom may we thank for referring you to our office? \_\_\_\_\_

**HEALTH PROFILE**

**This form is important as we focus on your ability to be healthy. Our goals are to address any chief concern(s) that may have brought you to this office. Secondly, we want to offer you the opportunity of improved health, wellness and quality of life in the future.**

❖ If you have no specific complaints please skip to the “General History” section of this form.

Briefly describe your chief concern(s) \_\_\_\_\_

Date symptoms appeared? \_\_\_\_\_ If you had this condition before, when? \_\_\_\_\_

How intense is the pain? *Mild Moderate Severe* Describe the pain. *Sharp Dull Achy Deep Shooting Burning*

Does your condition? *Come and Go* Or is it? *Constant* How did it start? *Gradually Suddenly Injury*

Is this condition interfering with your *Work Leisure Sleep Sports Exercise Hobbies Other* \_\_\_\_\_

Other help sought for this condition? *Chiropractor Medical Dr. Massage Physio Acupuncture Other* \_\_\_\_\_

Female: Are you pregnant? *Yes No Unsure*

Family History of Disease *Diabetes Cancer Heart Disease Asthma Allergies Other* \_\_\_\_\_

**GENERAL HISTORY**

Please **circle** all that apply at **PRESENT**. Please **underline** all that apply to the **PAST**.

- |                           |                     |                       |                             |
|---------------------------|---------------------|-----------------------|-----------------------------|
| Allergy/Asthma            | Back Pain           | Colds                 | Drug Dependency/Alcoholism  |
| Dizziness/Loss of Balance | Neck Pain           | Ear Noises            | Sprain/Strain               |
| Fatigue/Loss of Sleep     | Loss of Smell/Taste | Difficulty Breathing  | Loss of Hearing             |
| Headache/Migraines        | Fainting            | Urinary Problems      | IBS/Crohn’s                 |
| Numbness                  | Cold Hands/Feet     | Sinus Infection       | Stroke/TIA’s                |
| Ulcers                    | Swollen Joints      | High/Low Blood Press. | Shortness of Breath         |
| Nervousness/Depression    | Hot Flashes         | Heart Disease         | Heavy Menstrual Flow/Cramps |
| Constipation/Diarrhea     | Heartburn/Reflux    | Chest Pain            | Irregular Cycle             |
| Arthritis                 | High/Low Bloodsugar | Chronic Fatigue Syn.  | TMJ                         |
| Under/ Overactive Thyroid | Fast/Slow Heartbeat | Fibromyalgia          | Repetitive Strain Injury    |
| Plantar Faciitis          | Diabetes            | Anemia/Low Iron       | Cancer                      |

**TURN OVER PLEASE**

## LIFESTYLE QUESTIONS

On a daily basis we all experience physical, bio-chemical and psychological stresses that can accumulate and result in a serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will enable us to have a better understanding of your lifestyle and its stressors.

Circle your level of stress:     **Home** - High Medium Low     **Work** - High Medium Low

Have you had any major accidents? *Yes No* If yes, what happened and what year? \_\_\_\_\_

Have you had any surgery? *Yes No* If yes, what was done and what year? \_\_\_\_\_

Have you had any broken bones? *Yes No* If yes, which one(s) and what year? \_\_\_\_\_

Are you taking any over the counter or prescription drugs? *Yes No* If Yes, what, for what purpose and how often?

Please list your top three **negative** stresses in each dimension:

**1. Physical stress** (i.e. falls, work postures, accidents, lots of driving etc.)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

**2. Bio-Chemical stress** (i.e. smoke, unhealthy food, missed meals, not enough water etc.)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

**3. Psychological stress** (i.e. work, relationships, finances, low self-esteem etc.)

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

## HEALTH HABITS – Please Circle

**Alcohol**    *daily weekly monthly occasionally never*

**Caffeinated Coffee/Soda/Tea**    *daily weekly monthly occasionally never*

**Tobacco** *In past* How much? \_\_\_pk. **Currently** How much? \_\_\_pk.    *Socially Never*

**Exercise**    *Cardio* \_\_\_times wk.    *Strength training* \_\_\_times wk.    *Flexibility/stretching* \_\_\_times wk.

**Sleep**    *over 8 hrs. 6-8 hrs. under 6hrs. Do you sleep on your stomach back side*

*What type of mattress do you have? \_\_\_\_\_ How old is it? \_\_\_yrs. How many pillows do you use? \_\_\_\_\_*

**Vitamins/supplements**    *What do you regularly take, if anything? \_\_\_\_\_*

## CONSENT AND SIGNATURE

I consent to a professional and complete Creating Wellness Assessment. I understand that any fee for this service is due at the time of service and cannot be deferred to a later date.

Signature \_\_\_\_\_ Date \_\_\_\_\_