ND

DC

RMT

PT

CKG HEALTH QUESTIONNAIRE

CATALYST KINETICS GROUP

CHIEF HEALTH CONCERNS

Full Name: Date:

What is your primary health concern at this time?

Please Describe:

Date of Onset?

How did it Start?

Are you currently receiving any treatments? Are they helping? (e.g. medication, chiropractic, massage, physio, etc.)

Please List:

1:

2.

3.

What makes it worse?

What makes it better?

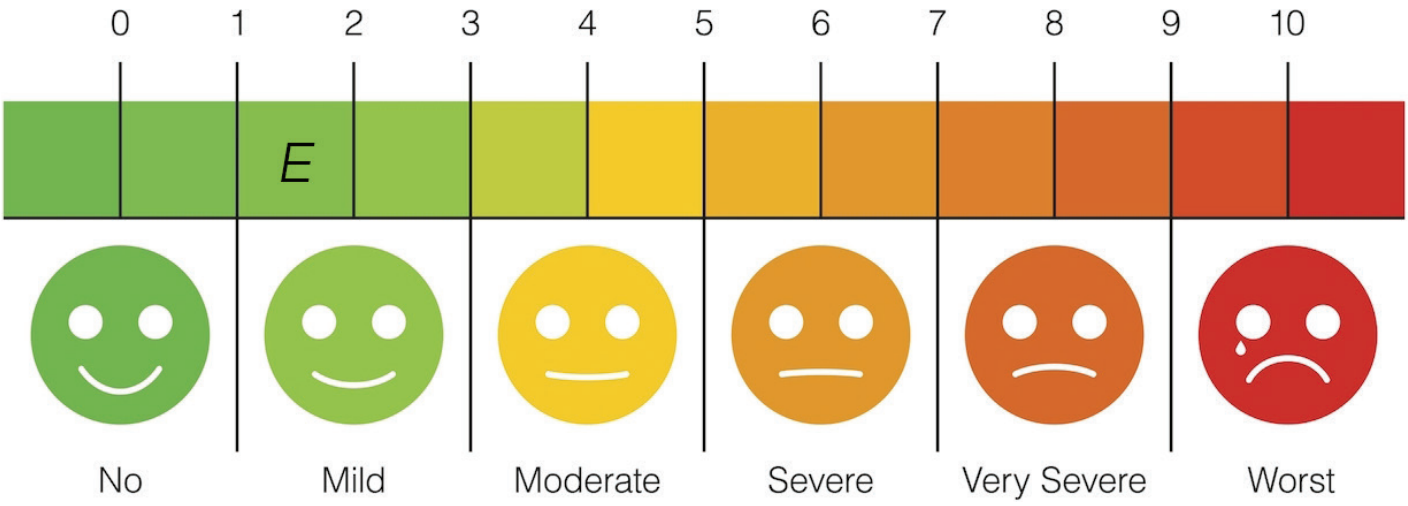
ADDITIONAL HEALTH CONCERNS

Please list any current and ongoing concerns in order of priority:

Describe Concern	Date of Onset	Prior Treatment / Approach	Result
E. Example: Hearth Burn	*Feb. 2014*	*Antacid*	*Good*
1.			
2.			
3.			
4.			
5.			

On the scale below please rate your health concerns in terms of severity / pain:

(Use "P" for Primary and 1, 2, 3, 4, 5 for any additional concerns referenced above. As per"E" for the Example)



Are any of your concerns affecting your quality of life? (Please check all applicable)

Work / School:	Yes ☐ No ☐	Recreation:	Yes ☐ No ☐	Sleep:	Yes ☐ No ☐	Exercise / Sport:	Yes ☐ No ☐
Eating:	Yes ☐ No ☐	Walking:	Yes ☐ No ☐	Sitting:	Yes ☐ No ☐	Intimate / Personal:	Yes ☐ No ☐

What are your overall health goals once your primary & secondary concerns have been resolved?

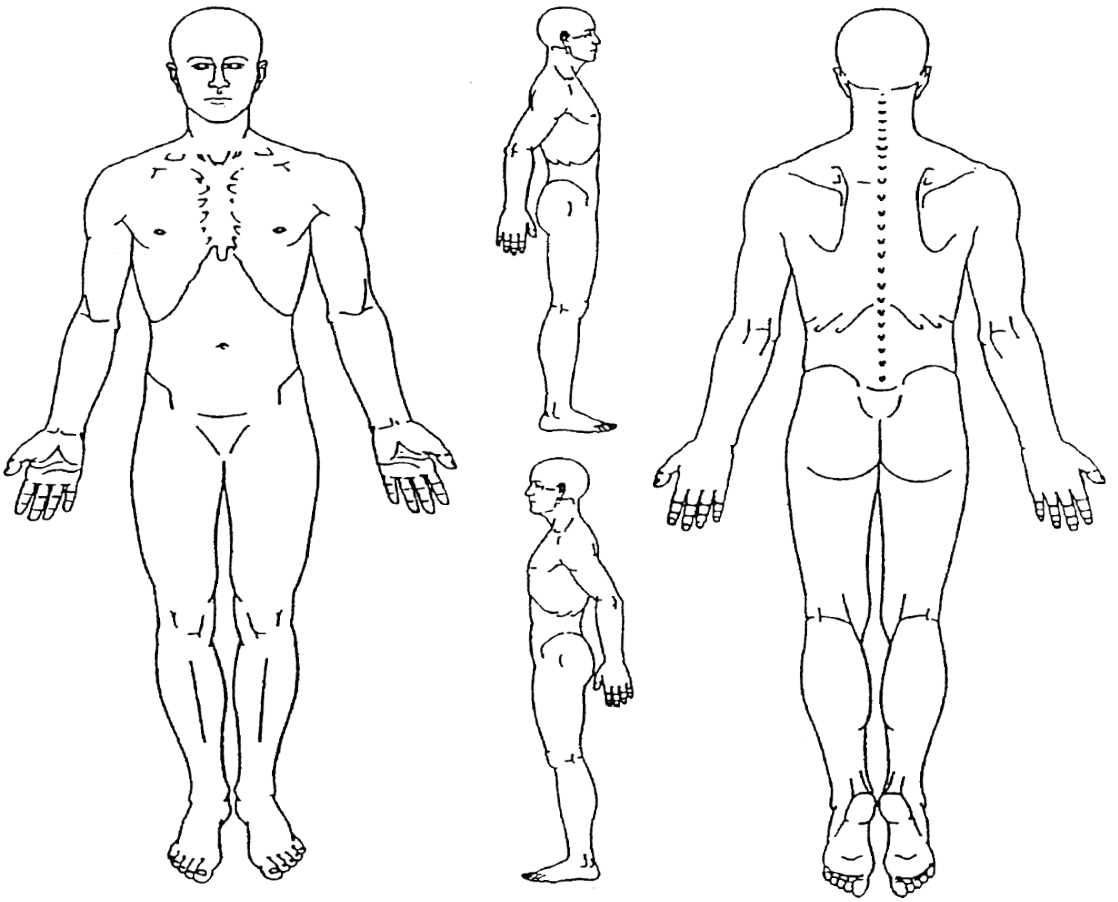
CATALYST KINETICS GROUP

PAIN DIAGRAM

INSTRUCTIONS: Use the symbols in the"key"below to indicate the type and location of the pain / discomfort AS IT FEELS TO-DAY. Place the letters on the part of the body where you feel any pain or discomfort.

KEY

A - ACHING N - NUMBNESS S - STABBING
B - BURNING P – PINS & NEEDLES T - TIGHTNESS



Practitioner Notes:

HEALTH HISTORY AND QUESTIONNAIRE

Contagious Diseases / Chronic Infections

Do you have any known contagious diseases / chronic infections at this time? Yes ☐ No ☐

If yes, please specify:

Allergies / Sensitivities: (Please check and list all allergies / sensitivities)

Food: _____

Medication: _____

Seasonal / Environment: _____

Other: _____

Accidents: (Please list all previous accidents including, MVA, sports, falls, workplace, etc.)

Year	Please describe: (injuries, treatment, outcome)

Head Trauma / Major Neck Injury: (Please list any head injuries you have sustained or possible concussions)

Year	Please describe: (mechanism of injury, any treatment, symptoms, loss of consciousness, outcome)

Headaches / Migraines:

Do you have a history of headaches or migraines? Yes ☐ No ☐

If yes, please specify:

Serious Illness / Hospitalization / Surgeries

Year	Description of Illness / Event	Outcome

HEALTH HISTORY AND QUESTIONNAIRE CONTINUED

Imaging / Blood Tests: (Please list recent imaging or blood tests)		
Year	Description of Imaging / Blood Test	Prescribed by?

Medications: (Please list all medications – current and recent, prescription and over the counter)				
Name of Medication	Dose	Indication	Prescribed by?	Date Started

Nutritional Supplements: (Please list all vitamins and supplements – current and recent)				
Name of Supplement	Dose	Indication	Prescribed by?	Date Started

General Health & Nutrition Habits			
Height:	Weight:	Maximum Weight:	Date:
Recent weight loss ☐ gain ☐		Reason / method for weigh loss / gain:	
Difficulty falling asleep:	Yes ☐ No ☐	Difficulty / Irritable when hungry:	Yes ☐ No ☐
Tired after full night's sleep:	Yes ☐ No ☐	Experience salt cravings:	Yes ☐ No ☐
Experience sugar cravings:	Yes ☐ No ☐	Need coffee / sweets between 3-5pm:	Yes ☐ No ☐
Experience fatigue after meals:	Yes ☐ No ☐	Do you eat snacks:	Yes ☐ No ☐
Do you eat breakfast:	Yes ☐ No ☐	Typical breakfast:	
What time do you eat breakfast:		Typical lunch:	
What time do you eat lunch:		Typical dinner:	
What time do you eat snacks:		Typical snacks:	
3 Healthiest foods you eat during the average week:			
3 Worst foods you eat during an average week:			

HEALTH HISTORY AND QUESTIONNAIRE CONTINUED

Dietary Restrictions:

Do you have any specific dietary restrictions or needs? Yes ☐ No ☐

If Yes, please list all applicable: (Vegetarian, Gluten-Free, Paleo, etc.)

Alcohol / Caffeine / Drug Consumption: (Please include current and previous consumption)

	Daily	Weekly	Monthly	Never	Amount	Years of Use
Alcohol	☐	☐	☐	☐		
Coffee /Caffeine	☐	☐	☐	☐		
Soda / Candy	☐	☐	☐	☐		
Tobacco	☐	☐	☐	☐		
Recreation Drugs	☐	☐	☐	☐		

Exercise / Sleep / Water Consumption / Meals / Work Activity

Exercise	9+/- Week ☐	7-8 Week ☐	5-6 Week ☐	3-4 Week ☐	1-2 Week ☐	None ☐
Sleep	9+ Hours ☐	8-9 Hours ☐	7-8 Hours ☐	6-7 Hours ☐	5-6 Hours ☐	<5 ☐
Water	8+ Cups ☐	6-8 Cups ☐	4-6 Cups ☐	2-4 Cups ☐	1-2 Cups ☐	None ☐
Meals	6+ Day ☐	5 Day ☐	4 Day ☐	3 Day ☐	2 Day ☐	1 Day ☐
Dining Out	9+ Week ☐	7-8 Week ☐	5-6 Week ☐	3-4 Week ☐	1-2 Week ☐	None ☐
Work Activity	Heavy Labour ☐	Light Labour ☐	Sitting ☐	Standing ☐	Walking ☐	Driving ☐

Stress Levels:

Overall stress level	Very High ☐	High ☐	Moderate ☐	Low ☐	None ☐
Health related stress	Very High ☐	High ☐	Moderate ☐	Low ☐	None ☐
Relationship stress	Very High ☐	High ☐	Moderate ☐	Low ☐	None ☐
Family stress	Very High ☐	High ☐	Moderate ☐	Low ☐	None ☐
Financial stress	Very High ☐	High ☐	Moderate ☐	Low ☐	None ☐
Workplace/School stress	Very High ☐	High ☐	Moderate ☐	Low ☐	None ☐

HEALTH HISTORY AND QUESTIONNAIRE CONTINUED

Family History:

Please check any conditions the you, or any of your family members have now or have had in the past:

	Self	Mother	Father	Sibling(s)	Paternal Grandparent	Maternal Grandparent
Alcoholism						
Anemia						
Arthritis						
Cancer						
Chicken Pox						
Cold Sores						
Deep Vein Thrombosis (DVT)						
Depression / Anxiety						
Diabetes						
Eczema / Psoriasis						
Epilepsy						
Goiter						
Gout						
Heart Disease						
Hepatitis A / B / C						
Herpes						
HIV / AIDS						
Hypertension / High Blood Pressure						
Kidney Disease						
Measles						
Mental Illness						
Mumps						
Pneumonia						
Rheumatic Fever						
Scarlet Fever						
Stroke						
Tuberculosis						
Ulcer(s)						
Other:						

Nationality:

Some health issues can be related to our familial nationality or heritage. Please list your heritage below:

Mother's Family: _____

Father's Family: _____

Antibiotic Use:

Have you recently had antibiotics prescribed for an illness, dental procedure, surgery, etc.? Yes ☐ No ☐

If yes, when and what were the antibiotics prescribed for:

What is the approximate number of times you have been prescribed antibiotics throughout your lifetime?

Have you ever been on long-term (1 month or more) antibiotic treatment? Yes ☐ No ☐

SYMPTOM CHECKLIST

Symptom Checklist:

MUSCULOSKELETAL – PLEASE CHECK ANY AREAS YOU EXPERIENCE PAIN AND/OR WEAKNESS (P = PAST / C=CURRENT)

P / C		P / C		P / C		P / C		P / C	
☐ ☐	Head	☐ ☐	Upper Back	☐ ☐	Shoulder	☐ ☐	Hand	☐ ☐	Foot
☐ ☐	Jaw / TMJ	☐ ☐	Lower Back	☐ ☐	Elbow	☐ ☐	Knee	☐ ☐	
☐ ☐	Neck	☐ ☐	Pelvis / Hips	☐ ☐	Wrist	☐ ☐	Ankle	☐ ☐	

GENERAL– PLEASE CHECK ALL THAT APPLY (P = PAST / C=CURRENT)

P / C		P / C		P / C		P / C		P / C	
☐ ☐	Low Appetite	☐ ☐	Chills	☐ ☐	Poor Balance	☐ ☐	Weight Loss	☐ ☐	Localized Weakness
☐ ☐	Strong Thirst	☐ ☐	Night Sweats	☐ ☐	Poor Sleep	☐ ☐	Weight Gain	☐ ☐	Sudden Energy Drop
☐ ☐	Cravings	☐ ☐	Tremors	☐ ☐	Sweat Easily	☐ ☐	Fatigue	☐ ☐	Bruise Easily

SKIN / HAIR– PLEASE CHECK ALL THAT APPLY (P = PAST / C=CURRENT)

P / C		P / C		P / C		P / C		P / C	
☐ ☐	Rashes	☐ ☐	Hives	☐ ☐	Dandruff	☐ ☐	Eczema	☐ ☐	Pigment Changes
☐ ☐	Ulcers	☐ ☐	Pimples	☐ ☐	Hair Loss	☐ ☐	New Moles	☐ ☐	Itching / Dry Skin

HEAD / EARS / EYES / NOSE / THROAT – PLEASE CHECK ALL THAT APPLY (P = PAST / C=CURRENT)

P / C		P / C		P / C		P / C		P / C	
☐ ☐	Sinuses	☐ ☐	Swollen Glands	☐ ☐	Contacts	☐ ☐	Cataracts	☐ ☐	Excess Saliva
☐ ☐	Sore Throat	☐ ☐	Poor Vision	☐ ☐	Ringing Ears	☐ ☐	Grinding Jaw	☐ ☐	Eye Strain
☐ ☐	Poor Hearing	☐ ☐	Earaches	☐ ☐	Sore Lips	☐ ☐	Sore Tongue	☐ ☐	Cavities
☐ ☐	Loss of Smell	☐ ☐	Facial Pain	☐ ☐	Dizziness	☐ ☐	Concussions	☐ ☐	Headaches
☐ ☐	Eye Pain	☐ ☐	Jaw Clicks	☐ ☐	Nose Bleeds	☐ ☐	Night Blindness	☐ ☐	Migraines

CARDIOVASCULAR / RESPIRATORY – PLEASE CHECK ALL THAT APPLY (P = PAST / C=CURRENT)

P / C		P / C		P / C		P / C		P / C	
☐ ☐	Chest Pain	☐ ☐	Fainting	☐ ☐	Hypertension	☐ ☐	Stroke	☐ ☐	Cold Hands / Feet
☐ ☐	Blood Clots	☐ ☐	Irregular Beat	☐ ☐	Murmurs	☐ ☐	Chronic Cough	☐ ☐	Swollen Feet / Ankles
☐ ☐	Palpitations	☐ ☐	Varicose Veins	☐ ☐	Pacemaker	☐ ☐	Asthma	☐ ☐	Shortness of Breath
☐ ☐	Pneumonia	☐ ☐	Wheezing	☐ ☐	Phlegm	☐ ☐	Bronchitis	☐ ☐	Coughing Blood

GASTROINTESTINAL / URINARY – PLEASE CHECK ALL THAT APPLY (P = PAST / C=CURRENT)

P / C		P / C		P / C		P / C		P / C	
☐ ☐	Nausea	☐ ☐	Pale Stool	☐ ☐	Gas	☐ ☐	Vomiting	☐ ☐	Abdominal Pain
☐ ☐	Belching	☐ ☐	Black Stool	☐ ☐	Diarrhea	☐ ☐	Ulcer	☐ ☐	Gall Bladder Disease
☐ ☐	Indigestion	☐ ☐	Rectal Pain	☐ ☐	Constipation	☐ ☐	Liver Disease	☐ ☐	Chronic Laxative Use
☐ ☐	Heartburn	☐ ☐	Hemorrhoids	☐ ☐	Blood in Stool	☐ ☐	Jaundice	☐ ☐	Trouble Swallowing
☐ ☐	Blood in Urine	☐ ☐	Incontinence	☐ ☐	Kidney Stones	☐ ☐	Increased Frequency	☐ ☐	Pain on Urination

NEUROLOGICAL – PLEASE CHECK ALL THAT APPLY (P = PAST / C=CURRENT)

P / C		P / C		P / C		P / C		P / C	
☐ ☐	Seizures	☐ ☐	Numbness	☐ ☐	Prone to Stress	☐ ☐	Mood Swings	☐ ☐	Considered Suicide
☐ ☐	Tingling	☐ ☐	Dizziness	☐ ☐	Irritable	☐ ☐	Anxiety	☐ ☐	Attempted Suicide
☐ ☐	Loss of Balance	☐ ☐	Fainting	☐ ☐	Concussions	☐ ☐	Depression	☐ ☐	Memory Problems

MALE – PLEASE CHECK ALL THAT APPLY (P = PAST / C=CURRENT)

P / C		P / C		P / C		P / C		P / C	
☐ ☐	Hernias	☐ ☐	Testicular Pain	☐ ☐	Testicular Mass	☐ ☐	Herpes	☐ ☐	Premature Ejaculation
☐ ☐	Sexually Active	☐ ☐	Gonorrhea	☐ ☐	Impotence	☐ ☐	Discharge	☐ ☐	Prostate Disease

FEMALE – PLEASE CHECK ALL THAT APPLY (P = PAST / C=CURRENT)

P / C		P / C		P / C		P / C		P / C	
☐ ☐	Heavy Menses	☐ ☐	Endometriosis	☐ ☐	Birth Control	☐ ☐	Breast Lumps	☐ ☐	Irregular Period
☐ ☐	Painful Menses	☐ ☐	Ovarian Cysts	☐ ☐	Pregnancies	☐ ☐	Menopause	☐ ☐	Painful Intercourse
☐ ☐	Clotting	☐ ☐	Abnormal PAP	☐ ☐	Miscarriages	☐ ☐	Breast Pain	☐ ☐	Nipple Discharge
☐ ☐	Discharge	☐ ☐	Herpes	☐ ☐	Abortions	☐ ☐	Cervical Dysplasia	☐ ☐	