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## Health and Well-Being History Form

Name:	
Address:	
Home Phone:	
E-mail:	
Date of Birth:	
Profession/Occupation:	
Why do you know BodyTalk?	

*\*Please answer the following questions honestly and to the best of your ability.*

**Thank you☺**

Describe **3 main concerns** for which you seek help.

**Frequency**(times per day/week) **Severity** (low, medium, high) **Pain** (1-10, low-high)

1.

2.

3.

Please list any other kind of healthcare professional you are seeing for this/these problem(s):

List the medications (including over the counter) you are presently taking:

Have you ever had this problem before, and if so when?

What daily activities are you finding difficult or are limited because of your above complaints?

List Symptoms which occur every day at the same time:

Please list any medical tests you have had within the past year:

What are your goals from BodyTalk? (.....and don't forget about the future and/or positive changes you would like to make; new career, expand your consciousness, habit changes, etc.)

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\*Please circle any of the following feelings you have experienced in the last few months:

- |              |                  |             |                  |
|--------------|------------------|-------------|------------------|
| Abused       | Despair          | Intimidated | Paranoid         |
| Aggravated   | Distress         | Intolerant  | Persecuted       |
| Agitated     | Easily irritated | Muddled     | Rejected         |
| Angry        | Fearful          | Nervous     | Restless         |
| Annoyed      | Grieving         | Outraged    | Sad              |
| Anxious      | Guilty           | Overwhelmed | Unable to grieve |
| Apprehensive | Helpless         | Overworked  | Uncertainty      |
| Criticizes   | Hopeless         | Panic       | Uneasy           |
| Depressed    | Impatient        | Paralyzed   | Worried          |

\*Please put a cross in the box that best describes the level of stress for the below listings.

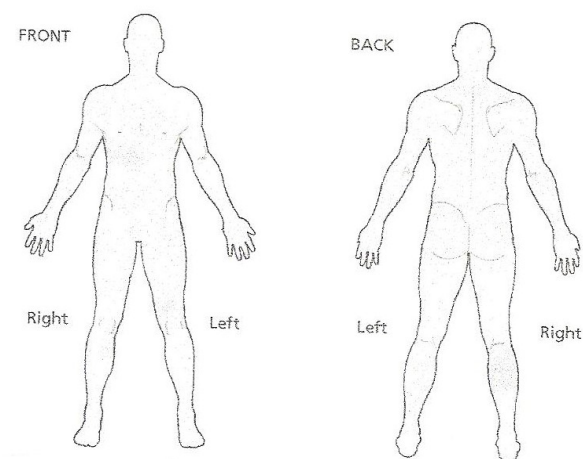
- |                            |                               |                                  |                                   |                                 |
|----------------------------|-------------------------------|----------------------------------|-----------------------------------|---------------------------------|
| My family stress is:       | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| My relationship stress is: | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| My work stress is:         | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| My financial stress is:    | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| My health stress is:       | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| My emotional stress is:    | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Other stress is:           | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |

How much time do you have for yourself to relax and what do you do to relax, hobbies, meditation, etc?

Do you exercise? And if so, what kind and how often?

How many hours a night do you sleep? Is it restful? If not, please explain:

*\*Please shade areas of pain or discomfort on the body diagrams and make comments on the side if necessary.*



COMMENTS:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Client signature



