The SAFTEY PIN SYSTEM is a unique approach to achieving and maintaining optimal health.

Today in North America and the rest of the western world, the priority in health care is to help people after they are already sick. That is a backwards approach to health care, and it is why we are getting sicker and sicker. Recently a medical researcher stated it plainly, “We are not living longer we are dying longer.” In other words, we have the capacity to keep people alive for longer and longer durations, but the majority of these people do not have a good quality of life. They cannot do most of the things that would allow them to live fulfilling lives.

Wouldn’t it be great if we could work at staying healthy, instead of waiting to get sick? What if we could roll back the biological clock on the average person? What if 50 really was the new 40? Or 60 was the new 50?

What if we could set up a system to allow you to do things at the age of 50, that you thought were impossible to do at the age of 40, or 30 for that matter?

That is exactly what the SAFETY PIN SYSTEM is designed to do. We are here to help you live longer and healthier, not die longer!!

How does the SAFETY PIN SYSTEM work?

1. DISCOVERY – HEALTH DANGERS

Unique questions will lead to new answers.

We will begin by looking at the current state of your health and wellness. In essence, how are you doing right now? We will also ask you some detailed questions about your history and your family health history.

It is important to understand that your current health problem started years ago and was multi-factorial in origin. The only exception would be an acute trauma like a car accident or severe sports injury. Even with acute traumas the extent of the injuries is most often dependent on your health before the accident. Your answers to the following questions offer up clues to what dangers your body is currently encountering and will give us a base line for comparison to future outcomes.

2. THE DISEASE CAUSATION ANALYSIS

We will explore which lifestyle factors are affecting your overall health and your ability to live fully alive. It is a well-known fact that 80% of the risk factors for the two most feared killers; heart disease and cancer, are lifestyle related. The same is true for the majority of chronic illnesses affecting patients today.

Let’s get started in understanding your problem and finding a solution.
PERSONAL INFORMATION

Name:

Address:

City: Postal/Zip Code:

Home #: Age: Birth date: (M) (D) (Y) Gender: M F

Workplace: Office #: Occupation:

Referred by: ☐ Single ☐ Widowed ☐ Married [SPouse's NAME]:

# of Children: and their ages:

PREVIOUS TRAUMAS

MOTORIZED VEHICLE ACCIDENTS

Year: ________ Injuries: _______________________________
Year: ________ Injuries: _______________________________
Year: ________ Injuries: _______________________________
☐ High Speed Collisions >40km/h? ☐ Vehicles unrepairable?
☐ Whiplash injury? ☐ Un-belted accident?

FALLS

Falls from heights ________________________________
Falls down stairs ________________________________
Other falls _______________________________________
Broken bones _________________________________
Childhood falls ________________________________

Falls from:
☐ Trees ☐ Roof ☐ Play structure ☐ Bicycle

SPORTS & RECREATION:

Sports injuries: _________________________________

Participation in High Impact Activities:
☐ Hockey ☐ Wrestling ☐ Basketball
☐ Running ☐ Mountain bike ☐ Climbing
☐ Football ☐ Gymnastics ☐ ________________

OCCUPATIONAL STRESSES

Occupation _______________________________________
Tasks ___________________________________________
Work injuries ___________________________________

Home injuries ___________________________________
My job requires:
☐ Heavy Lifting ☐ Awkward positions
☐ Repetitive stresses ☐ Sitting long periods

POSTURES & HABITS

☐ Sitting >6 hours/day ☐ Stomach sleeper
☐ Head forward posture

BIRTH TRAUMA was your delivery

☐ Difficult ☐ Forceps ☐ C-section
☐ Epidural ☐ Suction ☐ Resuscitation
**WHAT IS YOUR PRESENT HEALTH CONCERN?**

How long have you had this condition?

Have you had a similar condition in the past?

What activities aggravate your condition?

What relieves your condition?

Are you getting pain or numbness in your arms or legs?

Is your condition getting progressively worse?

   - Yes
   - No
   - It’s constant
   - It comes and goes

Pains are:

   - Sharp
   - Dull
   - Burning
   - Tightness
   - Throbbing

Pain severity (mark on the line, 0 no pain; 10 most severe)

How is this condition interfering with your life?

   - Work
   - Daily Routine
   - _____________________

Other doctors who treated this condition:

**FAMILY HEALTH PROBLEMS?**

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________

**MARK WITH AN X ON THE DIAGRAM ANY PAST OR PRESENT PAIN OR PROBLEMS AND CHECK THE APPROPRIATE CIRCLE BELOW:**

   - Headaches
   - Facial pain

   - Vision problems
   - Hearing problems

   - Shoulder: Pain / Numbness / Tingling (circle)

   - Arm: Pain / Numbness / Tingling (circle)

   - Hand: Pain / Numbness / Tingling (circle)

   - Hip: Pain / Numbness / Tingling (circle)

   - Knee: Pain / Numbness / Tingling (circle)

   - Foot: Pain / Numbness / Tingling (circle)

   - Neck Pain

   - Upper Back Pain

   - Middle Back Pain

   - Low Back Pain

   - Sacroiliac Pain

**OTHER HEALTH PROBLEMS?**

   ____________________________________________________________

   ____________________________________________________________

   ____________________________________________________________
PLEASE CHECK ANY OF THE FOLLOWING SIGNS OF ORGAN MALFUNCTION OR DIS-EASE YOU HAVE EXPERIENCED:

- Blurred /failing vision
- Deafness /ringing in ears
- Earaches
- Sore throat /tonsilitis
- Thyroid problems
- Sinus problems

**Cardiovascular system**
- Chest Pain
- Shortness of Breath
- Heart Medication
- High Blood Pressure Medication
- High Cholesterol Medication
- Swelling of Legs

**Respiratory system**
- Frequent bronchitis
- History of pneumonia
- Chronic cough
- Spitting up phlegm /blood
- Difficulty breathing
- Tuberculosis
- Pneumonia

**Digestive system**
- Heartburn / indigestion
- Stomach Cramps
- Constipation /diarrhea
- Food Allergy
- Irritable Bowel Syndrome
- Crohn’s Disease
- Ulcers
- Belching /gas
- Nausea or vomiting
- Liver /gall bladder trouble
- Colon trouble
- Black /bloody stool

**Musculoskeletal system**
- Painful Joints
- Painful Muscles
- Tendinitis
- Bursitis
- Arthritis

**General Symptoms**
- Fever / chills / sweats
- Frequent colds
- Fainting / dizziness
- Seizures / convulsions
- Headaches /migraine
- Neck pain /stiffness
- Tension across shoulders, L R
- Mid-back pain /stiffness
- Numbness /tingling: hands /arms

**General Symptoms**
- Skin problems
- Tremors
- Loss of balance
- Unexplained weight loss/gain
- Anemia
- Alcoholism
- HIV/AIDS
- Loss of sleep
- Poor memory /concentration
- Learning disability
- Irritable /nervous /tension
- Depression /emotional problems
- Decreased energy / fatigue
- Tired /lethargic
- Autoimmune Disease
- Antibiotic Use
- Cancer: _________________
- Allergies / Asthma
- Scoliosis / spinal curvature
- Low back pain / stiffness
- Faulty posture
- Painful tailbone
- Foot trouble, L R

**Females Only**
- Painful menstruation
- Cramps or backaches
- Passed menopause
- Currently pregnant? Y N
- Excessive /irregular flow
- Abnormal discharge
- Miscarriages #________
- Date of last menstrual period: ____________________
PERSONAL INFORMATION

How has your condition affected your quality of life? 
_____________________________________________________________________________________________________________

How has your condition affected you emotionally?  
_____________________________________________________________________________________________________________

How has your condition affected your family life and/or relationships? 
_____________________________________________________________________________________________________________

If left uncorrected, how do you see your condition affecting your life over the next 1-5 years? 
_____________________________________________________________________________________________________________

If you are a candidate for spinal reconstruction and if we were having this conversation 12 months from today, what has to happen over that time to make you feel happy with your progress? 
_____________________________________________________________________________________________________________

What is your greatest motivation (other than pain) for seeking out a solution for your condition?  
(Mobility, quality of life, family, participation in sports, etc.) 
_____________________________________________________________________________________________________________

Do you believe that this condition can improve? 
_____________________________________________________________________________________________________________

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I understand that any insurance coverage is an arrangement between the insurance company and myself. I understand that your Chiropractic Clinic will prepare any necessary reports and forms to assist me in submitting a claim to the insurance company. Furthermore, I understand and agree that all services rendered, are charged directly to me and that I am personally responsible for payment.

Our goal is to locate and correct vertebral subluxation, thereby restoring normal function to the spine, and removing any interference to nerve function, and maximizing the transmission of nerve impulses from brain to body. While we often see dramatic improvements in many diseases and conditions by restoring function to the spine and removing nerve interference, Chiropractic is not a treatment of any disease condition.

I understand and I am informed that, as in all health care, in the practice of Chiropractic there are some possible risks to care including, but not limited to, minor strains and sprains, and disc injuries. Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problems of the following – there have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes, or stroke-like occurrences, which are usually of a temporary nature. The chances of this happening are less than 1 in 5.8 million. Tests with or without X-Rays have been performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest, most effective forms of therapy for neck conditions. If you have any questions about this, please ask your Chiropractor.

I have read the above statements and consent to treatment.

Signature____________________________________________________ Date _____________________________
**EXERCISE**
Do you participate in aerobic exercise at least 30 minutes per day?
- 0 days /week
- 1-2 days /week
- 3-4 days /week
- 5-7 days /week

Do you lift weights or do resistance training?
- P90x
- Crossfit
- Gym
- Other ________________________________

What activities are you involved in that require balance?
- _____________________  - None

How often do you stretch per week?
- 0 days /week
- 1-2 days /week
- 3-4 days /week
- 5-7 days /week

**EMOTIONAL STRESS**
Are you currently experiencing, or have you ever experienced significant stress in the following areas?
- Marriage ________________________________
- Kids ____________________________________
- Finances ________________________________
- Work ____________________________________
- Elderly Parents - Caregiver ________________
- Recent Major Life Events (births, deaths) ____________

**CHEMICAL STRESSES: NUTRITION**
Do you feel that you make healthy food choices?
- Yes  - No  - Don’t Know

Do you have a high intake of fruits and vegetables?
- Yes  - No  - Don’t Know

Do you have a high intake of lean meat for protein?
- Yes  - No  - Don’t Know

Are you at your ideal body weight?
- Yes  - No  - Don’t Know

**CHEMICAL STRESSES: TOXIC LOAD**
Do you presently, or have in the past:
- Smoke?
- Carrying excessive weight?
- Consume Alcohol?
- Take recreational drugs?

**MEDICATIONS**
For what condition(s)? ______________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**SURGERIES**
For what condition(s)? List (year performed) ________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**FAMILY HEALTH HISTORY**
What significant health concerns have your family members experienced?

Parents / Siblings: ________________________________
________________________________________________________________________________
________________________________________________________________________________

Spouse / Partner: ________________________________
________________________________________________________________________________
________________________________________________________________________________

Children: ________________________________
________________________________________________________________________________
________________________________________________________________________________

Any other details that may assist the Doctor in understanding your lifestyle and health status: ________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________