Name:_____ Date:_____

Address:_____

Home Telephone ( )_____-_____ Cell phone ( )_____-_____ Work phone ( )_____-_____

Email address:_____ Social Sec #:_____ Birthdate:_____Age:_____

# of children:_____Occupation & Employer:_____

Single_____ Married_____ Divorced_____ Widowed_____ Referred by:_____

Reason for consulting our office?_____

Your Health Profile

Why This Form is Important

As a full spectrum chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office; and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual…not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Your Childhood Years (to age 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	Yes	No	Unsure
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take/use any drugs?	☐	☐	☐
Did you have any surgeries?	☐	☐	☐
Have you fallen/jumped from a height over 3 feet? (i.e. crib, bed, trees)	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	Yes	No	Unsure
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer from any other traumas (physical or emotional)?	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular chiropractic care?	☐	☐	☐

Comments:_____

_____

Adult-(18 to present)

	Yes	No
Do/did you smoke?	☐	☐
If yes, amount_____		
Do/did you drink alcohol?	☐	☐
If yes, amount_____		

	Yes	No
Do/did you play any adult sports?	☐	☐
Do/did you participate in extreme sports?	☐	☐

On a scale of 1-10, describe your stress level:
(1=none, 10=extreme)

Occupational_____

Personal_____

Have you had any surgeries? Please describe and date:_____

_____

Have you had any major falls/accidents? Please describe and date:_____

_____

List any medications you are taking *and what they are for*:_____

_____

Addressing the Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services,
please check (√) here_____--"Wish to have Chiropractic Wellness Services" and skip to "Family Health Profile"

Others please briefly describe the chief area of complaint, including the effect it has had on your life:

_____

When did you first notice the pain?_____ Have you had this condition in the past? ☐ Yes ☐ No

If you are experiencing pain, is it (check all that apply)... ☐ sharp ☐ dull ☐ comes and goes ☐ travels ☐ constant

Since the problem started, it is... ☐ about the same ☐ getting better ☐ getting worse

What makes it worse?_____ What makes it better?_____

With 1 being no pain and 10 being the worst pain imaginable, what would you rate your pain at its worst?_____now?_____

It interferes with (check all that apply)... ☐ work ☐ sleep ☐ walking ☐ sitting ☐ hobbies ☐ leisure

Have you seen another doctor for this condition? ☐ Yes ☐ No If so, whom?_____

Have you had previous chiropractic care? ☐ Yes ☐ No If so, with whom?_____
Approx. date last seen?_____ Were x-rays taken by this chiropractor? ☐ Yes ☐ No Approx. date:_____

Second condition? _____ Explain:_____

Please check (√) all symptoms you have ever had, even if they do not seem related to your current problem:

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins & needles in arms	☐ Loss of smell	☐ Back pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Irritability
☐ Fatigue	☐ Depression	☐ Panic attacks	☐ Mood swings
☐ Sleeping problems	☐ Cold hands	☐ Cold feet	☐ Hot flashes
☐ Cold sweats	☐ Lights bother eyes	☐ Problem urinating	☐ Heartburn
☐ Menstrual pain	☐ Menstrual irregularity	☐ Bowel irregularity	☐ Ulcers

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children:_____
Spouse:_____
Mother:_____
Father:_____

I hereby certify that the information given on this form is accurate to the best of my knowledge. My signature also certifies that I allow this office to examine me and I consent to spinal x-rays should the doctor advise their necessity.

_____ _____
Signature Date