PERSONAL HEALTH PROFILE

Name:				Date:
Home Address:		City:		Postal Code:
E-mail Address:		Home Phone: ( )		Work Phone: ( )
Gender: ❒ M ❒ F	Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed	Cell Phone: ( )		
Date of Birth: MM DD YY	Age:	Spouse's Name:		Spouse's Occupation:
Do you have children? ❒ No ❒ Yes	What are your children's names/ages?	If you are under 18, what are your Parents' names?		
How were you referred to our office?	Have you ever received chiropractic care before? ❒ No ❒ Yes Date of last visit? Years under care? Who was the Doctor? Where was the Doctor?			Who is your family MD? Phone number:
Occupation:		Employer:		
Work Address:		City:		Postal Code:
Extended Health Insurance: ❒ No ❒ Yes Company:		$ Participation / Year:		Renewal Date (i.e. Jan 1):

PRESENT STATE OF HEALTH

Is this visit for a wellness checkup and prevention or a specific concern?_____

If there is a specific concern please describe:_____

How long have you had this/these health concern(s)? _____

What makes this/these problems worse? (e.g. sitting, standing, etc)_____

What have you tried to address this concern?_____

At its worst, this problem interferes with:
❒ ability to work ❒ hobbies/sports ❒ family/social time ❒ sleep ❒ daily activities

If you don't get this problem corrected, do you think it will get worse in the next ❒ 1 year ❒ 2 years ❒ 5 years

Besides getting rid of the above concern, what is your main reason for wanting to get better? *(e.g. exercise, family, job live longer, live easier)*_____

On a scale of 1 to 10 (10 being the highest), rate your commitment to correcting this problem *(circle number):*

Not committed a all			Somewhat committed					Highly committed	
1	2	3	4	5	6	7	8	9	10

Let's begin at birth when you may have first damaged your nervous system, lost your wellness and began a journey to ill health.

Your birth process…

Was the delivery:

❒ long and/or difficult ❒ forceps ❒ vacuum extraction ❒ caesarean ❒ breech ❒ don't know?

Growth and development…

Did you get checked regularly by a chiropractor as a child? ❒ yes ❒ no

In your whole life, what were your 5 most serious physical traumas/stresses (eg. automobile jarring/impacts, work stress, recreational activities, sports, falls)

Trauma	Date of trauma
1)	
2)	
3)	
4)	
5)	

Mental/Emotional stress levels (1 → 10, 10 being high stress): _____

Caused by ❒ work ❒ home ❒ family relationship ❒ other_____

What surgeries have you had?

- _____
- _____

What medications/chemicals have you taken in the last year?

_____

Check off any of the following bodily warning signs you have experienced in the past:

❒ Tension/Headaches
❒ Mid Back Pain
❒ Neck Pain
❒ Tension Across Top of Shoulders
❒ Pain Between Shoulders
❒ Numbing/Tingling in Arms/Hands
❒ Wrist/Hand pain
❒ Chest Pain
❒ Heartburn
❒ High/Low Blood Pressure
❒ Poor Posture
❒ Dizziness
❒ Blurred/Failing Vision
❒ Deafness/Ears Ringing
❒ Earaches
❒ Low Back Pain
❒ Numbing/Tingling in Legs/Feet
❒ Hip Pain
❒ Iliotibial Band Syndrome
❒ Knee Pain
❒ Foot Pain
❒ Shin Splints
❒ Arthritis/Swollen Joints
❒ Allergies / Infections
❒ Digestive Problems
❒ Ulcer
❒ Bladder Problems
❒ Thyroid Problems
❒ Weight Trouble
❒ Breathing Problems
❒ Asthma
❒ Immune Problems
❒ Frequent Colds/Flu
❒ Heart Problems
❒ Difficulty Sleeping
❒ Anxiety/Depression
❒ Poor Concentration/Memory
❒ Sexual Dysfunction
❒ Infertility

Other Health Concerns:

_____

Women Only:

❒ Currently Pregnant
❒ Excessive Cramping/Pain
❒ Excessive Menstruation
❒ Irregular Cycle
❒ Hot Flashes
❒ Breast Pain/Lumps
❒ Date of last menstrual period:___ /___ /___

Many health concerns are related through family members. What health concerns has your family experienced?

Children:_____ Spouse/Partner:_____ Parents:_____

_____ _____ _____

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