Date: _________________ Last Name: ______________________ First: ________________ Middle:______________________

Address: ____________________________________ City/Town: ____________________ Prov: ________ Postal Code: ________________

Home Phone: _____________Business Phone: _____________Cell Phone: ____________E-mail_____________________________________

Date of Birth (m/d/y)______/______/______ Marital Status: ☐ M ☐ S ☐ D ☐ W

Sex:___M___F Occupation:____

Who May we "Thank" for referring you to our office? ____

Health Care #: ____________________ Do you have an Extended Health Care Plan? ☐ Yes ☐ No______________________________

Emergency contact: ____ Phone: ___________________

Name of Critical Care Doctor: ____

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. 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 optimum potential.

Past Chiropractic Care: ☐ Yes ☐ No This Year? ☐ Yes ☐ No Previous chiropractor: _________________________________

What other wellness professionals are currently part of your healthcare team?☐ Massage Therapist ☐Acupuncturist ☐ Other _____

List most recent surgeries and dates: ____

Medications (prescription and over the counter)
☐ Pain Meds ☐ Anti-inflammatories ☐ Birth Control ☐ Heart Meds ☐ Cholesterol Meds ☐ Other _______________________

Stress History

Please indicate whether you have ever experienced stress in the following areas. Your answers will enable us to determine which factors have contributed to your present health concerns.

Your Childhood Years

Stress in our youth sets the stage for problems in our adult life!

Childhood illnesses?	☐Yes ☐ No	Inhaler Use?	☐Yes ☐ No
Repeated/Prolonged Antibiotic use?	☐ Yes ☐ No	Prescription medication?	☐Yes ☐ No
Car Accident?	☐Yes ☐ No	Were you vaccinated?	☐Yes ☐ No
Surgery?	☐Yes ☐ No	As a child were you under regular Chiropractic Care?	☐Yes ☐ No
Fall/Jump from a height < 3 feet?	☐Yes ☐No	Youth Sports?	☐Yes ☐ No
Fall/Jump from a height > 3 feet? (i.e. crib, bunk bed, tree)	☐Yes ☐ No	Head Trauma?	☐Yes ☐ No
Other Traumas? (Physical or Emotional):	☐Yes ☐ No ___________________________________		

Comments: ____

Adult (18 to present)

Smoker?	☐Yes ☐ No	Contact/Extreme Sports?	☐Yes ☐ No
Alcohol Consumption?	☐Yes ☐ No	Drug Use?	☐Yes ☐ No
Car Accidents?	☐Yes ☐ No	On a scale of 1 to 10 describe your stress level:	
Fall/Jump from a height?	☐Yes ☐ No	(1= None, 10= Extreme) Occupational: _________ Personal: ________	

Addressing the Issues That Brought You To Our Office

Please check here ☐ **"Wish to have Chiropractic Wellness Services,"** if you have no symptoms or complaint and are here for wellness services. Skip to **"Health History"**
Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

Your Chief Complaint: ____

If you are experiencing pain is it…
☐ Sharp ☐Dull ☐ Comes & goes ☐ Travels ☐ Constant Other ☐ ___________

Since the problem started it is…. ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse? ____
What makes it better? ____

Yes it interferes with ☐ Work ☐ Sleep ☐ Walking ☐Sitting ☐Stairs ☐Lifting ☐Hobbies _________ ☐ Leisure __________

Other Doctors seen for this problem (Please List)
☐ Chiropractor ______________________
☐ Medical Doctor ______________________
☐ Other______________________________

Health History

Please check all the following health concerns that you have experienced, even if you do not think they relate to your present health condition

Allergies	☐Yes	☐ No	Heart Conditions	☐Yes	☐ No
Anxiety	☐Yes	☐ No	Immune System Disorders	☐Yes	☐ No
Arthritis	☐Yes	☐ No	Infertility	☐Yes	☐ No
Asthma	☐Yes	☐ No	Kidney Disease	☐Yes	☐ No
Back Pain	☐Yes	☐ No	Menstrual Cramps	☐Yes	☐ No
Bladder Problems	☐Yes	☐ No	Mood Swings	☐Yes	☐ No
Cancer	☐Yes	☐ No	Neck Pain	☐Yes	☐ No
Circulatory/Vascular Disease	☐Yes	☐No	Numbness/Tingling	☐Yes	☐ No
Depression	☐Yes	☐ No	Osteoporosis	☐Yes	☐ No
Diarrhea	☐Yes	☐ No	Sinus Troubles	☐Yes	☐ No
Digestive problems	☐Yes	☐ No	Skin Conditions	☐Yes	☐ No
Dizziness	☐Yes	☐No	Urinary Difficulty	☐Yes	☐No
Headaches	☐Yes	☐ No	Vertigo	☐Yes	☐No
Heartburn/Reflux	☐Yes	☐ No	Other ____________	☐Yes	☐ No

Are there any other health concerns that you believe we should be aware of? (MS, Diabetes, Crohn's) ☐Yes ☐No

____

On a scale of Poor, Good or Excellent describe your:

Diet___________ Exercise____________ Sleep___________ General Health___________

Which best describes your reason for consulting our office?

☐ I have a specific concern and require only help with this concern
☐ I want to ensure that my health concerns do not become an ongoing problem that will impact my future health
☐ I want to be healthier five years from now then I am today