

Name: _____ Patient #: _____ Age: _____ Date: _____

Address: _____
Residence and mailing City State Zip Code

Home Telephone () _____ Work Phone () _____

Email Address _____ Male _____ Female _____

Birthdate _____

Occupation/Employer's Name and address _____

Single _____ Married _____ Divorced _____ Widowed _____ Spouse's Occupation/Employer _____

No. of children: _____

Reason for consulting our office? _____

Who may we Thank for referring you to 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.

THE BEGINNING 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.

YOUR CHILDHOOD YEARS

YES NO UNSURE

YES NO UNSURE

Did you have any childhood illnesses?

Was there any prolonged use of medicine such as antibiotics or an inhaler?

Did you have any serious falls as a child?

Did you play youth sports?

Did you suffer any other traumas (physical or emotional)

Did you take / use any drugs?

Were you vaccinated?

Did you have any surgery?

Have you fallen / jumped from a height over three feet? (i.e. crib, bunk bed, trees)

As a child, were you under regular Chiropractic care?

Were you involved in any car accidents as a child?

COMMENTS: _____

ADULT - (18 TO PRESENT)

YES NO

YES NO

Do / did you smoke?

Do / did you play any adult sports?

Do / did you drink alcohol?

Do / did you participate in extreme sports?

Have you been in any accidents?

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

Have you had any surgery?

Occupational _____

Personal _____

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

Diet _____ Exercise _____ Sleep _____ General Health _____

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 need to briefly describe the chief area of complaint, including the effect it has had on your life.

If you are experiencing pain, is it...

- Sharp Dull Comes and goes Travels Constant

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

What makes it worse:

Yes, it interferes with: Work Sleep Walking Sitting Hobbies Leisure

Other Doctors seen for this problem (please list)

- Chiropractor _____
 Medical Doctor _____
 Other _____

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

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Pins and Needles in arms | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers |

List any medications you are taking _____

Family Health Profile:

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

Children _____
Spouse _____
Mother _____
Father _____
Brothers _____
Sisters _____
Others _____

Have you ever:

- Bought bottled water: YES NO
Belonged to a health club: YES NO
Consumed vitamins or supplements: YES NO

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Signature

Date

