What Brought You In

Please answer all questions completely.

If you have no symptoms or complaints and are here to experience Chiropractic Wellness Services, please check here ❒ and skip to the "Family Health Profile".

All others, please briefly describe below the main area of complaint, including the effect it has had on your life.

Main Area of Complaint

Briefly describe: _____

_____

_____

_____

_____

_____

_____

_____

If you are experiencing pain, is it:

Sharp Dull Constant
Travels Comes & Goes

Since the problem started, is it:

About the same Getting better
Getting Worse

What makes it worse: _____

_____

_____

Yes, it interferes with:

Work Sleep Walking
Sitting Hobbies Leisure

List all doctors seem for this problem:

_____

_____

West
Chiropractic Clinic

Dr. Chris West
Dr. Roger Barnick
Dr. Kris King

4700 W. Hardy Street, Suite M
Hattiesburg, MS 39402

Personal Health Profile

Circle all symptoms you have ever had, even if they do not seem related to your current problem:

Headaches	Pins and Needles in arms	Dizziness
Numbness in fingers	Fatigue	Sleeping problems
Diarrhea	Cold sweats	Mood swings
Loss of smell	Pins and needles in legs	Buzzing in ears
Numbness in toes	Depression	Neck stiff
Constipation	Lights bother eyes	Menstrual pain
Fainting	Back pain	Ringing in ears
Loss of taste	Irritability	Cold hands
Fever	Problem urinating	Menstrual irregularity
Neck pain	Loss of balance	Nervousness
Stomach upset	Tension	Cold feet
Hot flashes	Heartburn	Ulcers

List any medication you are currently 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 list below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brother(s): _____

Sister(s): _____

Other: _____

Have you ever:

Bought bottled water Belonged to a health club
Consumed vitamins/supplements

All statements 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 _____

Personal Information

Name _____

Age _____ Marital Status _____

Sex _____ Date of Birth _____

Number of Children: _____

Social Security # _____

Driver's License # _____

Address _____

City/State/Zip _____

Occupation _____

(Indicate if child, student, housewife, unemployed, retired)

Employer Name & Address _____

_____

_____

_____

Business Phone _____

Company Name _____

Location _____

Reason for consulting our office _____

_____

_____

Who referred you? _____

Spouse's Information

Name _____

Employer Name & Address _____

_____

_____

Business Phone _____

Location _____

Personal Health Profile (cont'd)

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 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.

During your childhood years...

did you have any childhood illnesses?	Yes / No / Unsure
did you have any serious falls as a child?	Yes / No / Unsure
did you play youth sports?	Yes / No / Unsure
did you take/use any drugs?	Yes / No / Unsure
did you have any surgery?	Yes / No / Unsure
did you fall/jump from a height over three feet (i.e. crib, bunk bed, trees)?	Yes / No / Unsure
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?	Yes / No / Unsure
did you suffer any other physical or emotional traumas?	Yes / No / Unsure
were you vaccinated?	Yes / No / Unsure
were you under regular Chiropractic care?	Yes / No / Unsure

Comments: _____

_____

_____

Your Adult Years (18 to present)

Did/do you smoke? Yes No

Describer your health on a scale of Poor, Good, and Excellent

Diet _____ Exercise _____

Sleep _____ General Health _____

Patient Signature: _____ Date: _____