WELCOME! WE ARE GLAD YOU ARE HERE!

Personal Information:

Full Name: _____ Date: _____

Address: _____ City: _____ State: ___ Zip: _____

Email: _____

Your email will be used for appointment reminders, receipts, occasional health info, etc. You may unsubscribe anytime.

Date of Birth: _____ /_____ /_____ Current Age: _____

Mobile Phone: _____ Home Phone: _____

Married Single Divorced Widowed Spouse / Partner's Name: _____

Children / Ages: _____

Who may we thank for referring you? _____

Your Primary Health Concerns:

Health Concern	Rate of Severity 1 = mild 10 = severe	Has this happened before? When?	How long have you suffered with this?	Do you know what caused this?
1.				
2.				
3.				

What solutions have you tried to address these concerns? _____

Why do you think they **did not** work? _____

Have you become discouraged about any of these concerns? _____

Do these concerns interfere with any of the following:

☐ Sleep	☐ Work	☐ Daily Routine	☐ Sports / Exercise	☐ Other

Have you seen a chiropractor before? Please share your experience? _____

_____

Please list all prescription medications and /or over the counter products you use and the reason / intent for use:

Substance Name	Purpose

Let's Talk Stress

We are subjected to constant chronic low levels of physical stress, chemical stress, emotional/mental stress, electromagnetic stress and possibly other stresses. These stressors accumulate over time and left unaddressed can cause the vast majority of health challenges. Please pay close attention to the lists of common stressors and identify the ones you currently experience, as well as those you've experienced in the past.

Physical Stress	Past	Current	Details
Poor Posture	☐	☐	
Heavy Lifting	☐	☐	
Sitting / Driving Long Term	☐	☐	
Sports Injuries	☐	☐	
Childhood Falls	☐	☐	
Adult Falls	☐	☐	
Any Auto Accidents	☐	☐	
Computer Use / Desk Work	☐	☐	
Repetitive Activities	☐	☐	
Other:	☐	☐	

Chemical Stress	Past	Current	Details
Cleaning Products	☐	☐	
Additives / Preservatives	☐	☐	
Aspartame / Diet Drinks	☐	☐	
Dehydration	☐	☐	
Medications / OTC Meds	☐	☐	
Tobacco	☐	☐	
High Sugar Consumption	☐	☐	
Poor Diet	☐	☐	
Pollution Exposure	☐	☐	
Other:	☐	☐	

Emotional / Mental Stress	Past	Current	Details
Anxiety / Worry	☐	☐	
Depression	☐	☐	
Abuse / Neglect	☐	☐	
Family / Relationship Stress	☐	☐	
Financial Stress	☐	☐	
Grief	☐	☐	
PTSD	☐	☐	
Anger / Irritability	☐	☐	
Work Stress / Deadlines	☐	☐	
Other:	☐	☐	

Where in your body do you hold or carry your stress? Head / Neck / Shoulders / Jaw / Mid-Back / Low Back / Feet / Hips Stomach / Other: _____

Do you think your current health problem/challenge could be caused by: ☐ physical stress, ☐ chemical stress,

☐ emotional/mental stress, ☐ all of the above? Comments: _____

Which of these have you experienced in the last 6 months?

☐ Sleeping Difficulties	☐ High Blood Pressure	☐ Digestive Issues / Reflux
☐ Chronic Fatigue	☐ Mood Swings	☐ Weight Issues / Belly Fat
☐ Memory Fog	☐ Food Cravings	☐ Headaches
☐ Weakened Immunity	☐ Poor Concentration	☐ Racing Mind
☐ Hormonal Issues	☐ Accelerated Aging	☐ Cold Hands &/or Cold Feet
☐ Anxiety	☐ Depression	☐ Migraines
☐ Allergies	☐ Low Energy	☐ Vision / Hearing Issues
☐ Hyperactivity	☐ Dizziness / Vertigo	☐ Constipation
☐ Numbness	☐ Balance Issues	☐ Jaw Issues / TMJ
☐ Asthma	☐ Food Intolerance	☐ Gas Pain / Bloating
☐ Indigestion / Heartburn	☐ Blood Sugar Issues	☐ Skin Conditions / Rash
☐ Teeth Grinding	☐ Irritable	☐ Poor Emotional Expression

Please list your top three health goals:

1. _____
2. _____
3. _____

How would your life change if you did not have the health conditions/challenges indicated on this form?

_____

_____

_____

How committed are you to living a healthier life on a scale of 1-10 with 10 being the healthiest life possible? _____

Do you view your health as an investment or an expense? _____

Is there any other information you would like to share? _____

_____

_____

I acknowledge that I have answered all of the above questions completely and to the best of my ability.

Patient Name (Printed): _____ Date: _____

Patient Signature: _____

Dr. Antoinette Biegaj, DC 843.856.9466
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Thank You

FAMILY WELLNESS CHIROPRACTIC