

Your Wellness History – Health Profile

Date: _____

Name: _____ DOB: _____ Age: _____ / Male Female

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

Home # () _____ Work: () _____ Cell: () _____

Best time to contact: _____ How did you hear about the office? _____

Email address: _____ Status: Single Married Divorced Widowed

of Children: _____ Names/Age: _____

Occupation: _____ Employer Name/Address: _____

Rate your health and wellness.

Place an 'X' that denotes where you believe is your current level of wellness.
Place an 'O' indicating where you would like your wellness to be.



YOUR HEALTH PROFILE

➤ What brings you into our office today?

Please briefly describe, including the impact it has had on your life. If you're only here for chiropractic wellness services please skip this part and go to "General History" on the next page.

Rate Severity (scale 1-10, 1 being mild) _____ When and how did this start? _____ Are symptoms constant or intermittent? _____

➤ Since the problem started it is; ___the same ___getting better ___getting worse

What makes the problem worse? _____

➤ What, if anything, makes the problem feel better? _____

➤ Does this interfere with your; ___Leisure ___Work ___Sleep ___Sports ___Other

➤ Have you seen other doctors for this condition? ___Chiropractor ___MD ___Other

Name/Address: _____ Date: _____

What was the diagnosis: _____



Krauza Family Chiropractic:
A Creating Wellness
Center

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GENERAL HISTORY

➤ Please list all medications you are taking, and why; (Prescription and non-prescription)

➤ Have you had any surgeries and/or hospitalizations? ___Yes ___No

If yes, briefly explain: _____

➤ Have you ever had any work related injuries? ___Yes ___No

If yes, briefly explain: _____

➤ Have you ever had any slips, falls or auto accidents? ___Yes ___No

If yes, briefly explain: _____

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"/> Buzzing in ears | <input type="checkbox"/> Irritability | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Constipation | <input type="checkbox"/> Urinary problem | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Eyes bothered by light | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Stiff neck |
| <input type="checkbox"/> Ulcers | | | |



YOUR GOALS

➤ On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/psychological/lifestyle stress levels:

Scale = ____ Occupational stress: _____

Scale = ____ Personal stress: _____

➤ On a scale of 1 to 10 (1 = poor, 10 = excellent), describe your habits and condition as it relates to:

Eating____ Exercise____ Sleep____ General Health____ Wellness lifestyle____

At our office we're concerned about your health and wellness goals. Please take a moment to list your goals

Wellness Goals		
Be Fit. <i>(Physical)</i>	Eat Right. <i>(Nutritional)</i>	Think Well. <i>(Psychological)</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check all that are relevant.

<u>Do you:</u>	<u>Would you like to know more about:</u>
<input type="checkbox"/> Water - Drink ½ your body weight in ounces	<input type="checkbox"/> Proper Nutrition and meal planning
<input type="checkbox"/> Exercise regularly	<input type="checkbox"/> Proper exercise routines and techniques
<input type="checkbox"/> Take vitamins or supplements	<input type="checkbox"/> How to deal with LifeStyle stress

Thank you for filling out this form.
It is your first step to Creating Wellness!

I consent to a professional and complete chiropractic examination, and to any radiographic examination that the doctor deems necessary. I understand that all fee's for services rendered are due at the time of service and cannot be deferred to a later date.

Signature: _____ Date: _____

Please return this form to our staff and someone will be right with you.

