YOUR HEALTH PROFILE

Name:_____Age:_____Date:_____

Address: _____

Street City State Zip

Home Phone:(_____)_____ Work Phone:(_____)_____ Cell Phone:(_____)_____

Email Address: _____Male:_____ Female:_____

Social Security #:_____Driver's Lic. # _____ Birth Date:_____

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

Occupation/ Employer's Name: _____

Spouse's Occupation/ Employer: _____

Person to contact in case of emergency :_____ Phone #:(____)_____

Who may we Thank for referring you to our office? _____

Reason For Consulting our office?_____

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 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 things starting at birth. Please answer the following questions to the best of your ability.

Your Childhood Years

	Yes	No	Unsure
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious fall as a child?	☐	☐	☐
Did you play sports?	☐	☐	☐
Did you take/use any drugs?	☐	☐	☐
Did you have surgery?	☐	☐	☐
Did you ever fall/ jump from a height over three feet? (i.e. crib, bunk bed, trees)	☐	☐	☐
Were you involved in any car accidents?	☐	☐	☐

	Yes	No	Unsure
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas? (emotional or physical)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under regular chiropractic care?	☐	☐	☐

Comments:_____

_____

Adult—(18 to Present)

	Yes	No	Unsure
Do/did you smoke?	☐	☐	☐
Do/did you drink alcohol?	☐	☐	☐
Have you been in any accidents?	☐	☐	☐
Have you had any surgery?	☐	☐	☐
(Women) Are you pregnant?	☐	☐	☐

Due Date:_____

	Yes	No	Unsure
Do/ did you play any adult sports?	☐	☐	☐
Do/did you participate in extreme sports?	☐	☐	☐

On a scale of 1-10 describe your stress levels (1=none/10=extreme)

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 ☐

Others, please 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/Aching ☐ Comes and goes

☐ Stabbing ☐ Burning ☐ Constant

Since the problem started, is it…

☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse:_____

What makes it better:_____

Dose it interfere with: ☐ Work ☐ Sleep ☐ Walking

☐ Sitting ☐ Hobbies ☐ Leisure

Other doctors seen for this problem (please list)

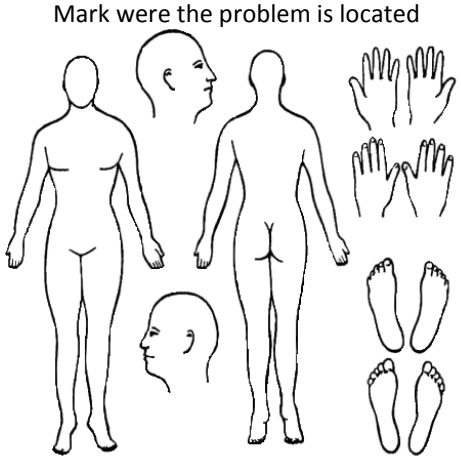
Chiropractor:_____

Medical Doctor:_____

Other:_____

TELL US WHERE YOU HURT

Mark were the problem is located



Rate your two worst areas of pain:

1 Being the least pain

10 Being the worst pain

Ex. Neck

1 2 3 (4) 5 6 7 8 9 10

1:_____

1 2 3 4 5 6 7 8 9 10

2:_____

1 2 3 4 5 6 7 8 9 10

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

☐ Headaches	☐ Dizziness	☐ Lights bother eyes	☐ Loss of Balance
☐ Neck Pain	☐ Pins and needles in arms	☐ Weakness in the arms	☐ Ringing/buzzing in the ears
☐ Neck stiffness	☐ Cold Hands	☐ Cold Feet	☐ Fainting
☐ Back Pain	☐ Pins and needles in legs	☐ Weakness in the legs	☐ Numbness in the groin
☐ Nervousness	☐ Depression	☐ Irritability	☐ Tension
☐ Diarrhea	☐ Constipation	☐ Stomach Upset	☐ Heartburn
☐ Fatigue	☐ Sleeping Problems	☐ Problem Urinating	☐ Ulcers
☐ Mood swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Fever

List any Medications you are taking:_____

_____

Allergies:_____

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 additional health conditions or concerns you may have about:

You:_____

Spouse:_____

Children:_____

How many children do you have?_____ What ages are they?_____

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***