

General Information

Today's Date ____-____-____

Name _____ Age _____ Date of Birth ____-____-____

Address _____ E-Mail Address _____

City _____ State _____ Zip _____ Social Security # ____-____-____

Phone #'s: Home _____ Cell _____ Work _____ Fax _____

Occupation _____ Employer _____

Single Married Divorced Widowed Male Female # of Children _____

Name of Spouse _____ Names & ages of Children _____

Main reason for consulting our office today? _____

I am seeking: Temporary relief only Correction of the underlying condition, if possible

I want the Doctor to recommend what he feels is best for me

Referred by: _____ Doctor Friend Family Co-worker

Are you here because of Car accident Work injury Other injury _____

Previous chiropractic care? Yes No If yes, when was your last adjustment? _____

Your Health Profile

Why this form is important - As a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a lifetime of health, happiness and vitality. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes not until it's too late. Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better assess your current status and more accurately determine what course of care will best help you reach your true health potential.

The beginning Years - Many of the health challenges that people face later in life have their origins in stresses from the developmental years, some even starting at birth. Please answer to the best of your memory or knowledge.

Birth History: Please check those items that apply to you.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Mother smoked/drank/drugs in preg. | <input type="checkbox"/> Epidural/Meds in labor | <input type="checkbox"/> Breech delivery | <input type="checkbox"/> c-section |
| <input type="checkbox"/> Forceps delivery | <input type="checkbox"/> Vacuum extractor used | <input type="checkbox"/> Induced Labor | <input type="checkbox"/> Complications |
| <input type="checkbox"/> Other _____ | | | |

Childhood Years (age 0-17yrs) - Please check those items that apply to you.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Recurrent childhood illness | <input type="checkbox"/> Serious falls | <input type="checkbox"/> Active in Sports | <input type="checkbox"/> Very inactive |
| <input type="checkbox"/> Car accident(s) | <input type="checkbox"/> Surgery/Stitches | <input type="checkbox"/> Alcohol/Drug abuse | <input type="checkbox"/> Smoker |
| <input type="checkbox"/> Antibiotics/ other meds | <input type="checkbox"/> Vaccinated | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Severe Emotional Stress |
| <input type="checkbox"/> Chiropractic care | <input type="checkbox"/> ADD/ADHA meds | <input type="checkbox"/> Other _____ | |

Adult Years (Age 18 to present)

- | | | | |
|---|---|---|--------------------------------------|
| <input type="checkbox"/> Present smoker | <input type="checkbox"/> Former smoker | <input type="checkbox"/> OTC/prescription Meds | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Surgery Stitches | <input type="checkbox"/> Sports | <input type="checkbox"/> Car accidents | <input type="checkbox"/> Work injury |
| <input type="checkbox"/> High job stress | <input type="checkbox"/> High personal stress | <input type="checkbox"/> Sit a lot | <input type="checkbox"/> Drive a lot |
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Not enough sleep | <input type="checkbox"/> Poor diet | <input type="checkbox"/> No exercise |
| <input type="checkbox"/> Flat feet | <input type="checkbox"/> Wear orthotics/Lifts | <input type="checkbox"/> Severe health problems | <input type="checkbox"/> Hard falls |
| <input type="checkbox"/> Broken Bones _____ | <input type="checkbox"/> Other injuries _____ | | |

(Over please)

Addressing the issues that brought you to our office

**If you have no symptoms and you are here for wellness care, please check here: "I am looking for chiropractic wellness services" and skip to "Family Health Profile" near the bottom of the form.

Chief Complaint(s) _____

When did it start? _____ Previous Episodes? Yes No When? _____

How is it different than previous episodes? _____

Was there an injury? Yes No Explain _____

If no, what triggered the problem? _____

Is the pain Sharp Dull Constant Intermittent Traveling Radiating
 Mild Moderate Moderately Severe Severe Intolerable

Since it began, is it... About the same Getting better Getting worse Variable

What makes it better? _____

What makes it worse? _____

Is there a time of day that is typically worse? Yes No If yes, when? _____

How has this affected your life? _____

Effect on daily activities? No Effect Extra Effort Required Occasional Limits Frequent, Severe limits

Other Doctors or treatments you have tried for this problem:

Chiropractor _____

Medical Doctor _____

Other _____

System Review and History - Please check all recurring or severe symptoms you have had, even if they do not seem related to your current problem(s).

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Sinus Problem-Allergies | <input type="checkbox"/> Dizziness/Vertigo |
| <input type="checkbox"/> Buzzing/ringing in ears | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Light bothers eyes |
| <input type="checkbox"/> Nervousness/Anxiety | <input type="checkbox"/> Recurring Infection | <input type="checkbox"/> Tension/Stress | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Neck stiffness/Pain | <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Cold hands |
| <input type="checkbox"/> Back Stiffness/Pain | <input type="checkbox"/> Pins & Needles in legs/feet | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Foot problems |
| <input type="checkbox"/> Cold feet | <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Diarrhea/Constipation/Gas | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Jaw/TMJ problems | <input type="checkbox"/> Digestive disorders | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Problems urinating | <input type="checkbox"/> Fertility problems | <input type="checkbox"/> Depression | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Irritability/Mood swings | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Cancer _____ | | <input type="checkbox"/> Other _____ | |

Females: PMS Miscarriage Menopause Hot Flashes

Current Height _____ Weight _____ Has your weight changed significantly in the past year? Yes No

Are there other health issues that we should know in determining the best method of caring for you? Yes No

If yes, explain: _____

Family Health Profile- Our office is not only interested in your health but also that of your family and loved ones.

Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Parents: _____

Siblings or others: _____

Healthy Lifestyle

Is your diet: Good Fair Bad Getting better Getting worse

Do you take vitamins? Yes No Do you exercise? Yes No

In five years, do you think you will be: Healthier Less healthy I have no idea

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible.

Signed _____ Date _____