Name:_____DOB:_____Age:_____Date:_____

Address:_____City/St:_____Zip:_____

Home( ) _____Cell( ) _____ Work ( )_____

Male:_____ Female:_____ Single:_____ Mar:_____ Div:_____ Wid:_____ No. of Children:_____

Email: _____SSN: _____

Employer:_____ Occupation: _____

Spouse's Name:_____ Spouse's Occupation:_____

How were you referred to our office? _____

YOUR HEALTH PROFILE

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 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.

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

CHILDHOOD YEARS	YES	NO	Unsure
Did you play youth sports?	☐	☐	☐
Did you take/use any drugs?	☐	☐	☐
Were you vaccinated?	☐	☐	☐

Childhood illnesses: _____

Surgeries:_____

Personal:_____

Falls/Accidents:_____

_____

ADULTHOOD YEARS	YES	NO	Unsure
Do / did you smoke?	☐	☐	☐
Do / did you drink alcohol?	☐	☐	☐
Do / did you play adult sports?	☐	☐	☐

On a scale of 1-10 describe your stress level:

(1=none/10=Extreme) Occupational:_____

On a scale of Poor, Good, Excellent describe your:

Diet: _____ Sleep: _____

General Health: _____ Exercise:_____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

If you are experiencing pain is it… ☐ Sharp ☐ Dull ☐ Achy / Freq: ☐ Constant ☐ Comes & goes

Since the problem started, it is … ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse: ☐ Walking ☐ Work ☐ Sleep ☐ Hobbies ☐ Leisure ☐ Other_____

Other Doctors seen for this problem (please list)

☐ Chiropractor _____ ☐ Medical Doctor _____ ☐ Other _____

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

☐ Headaches	☐ Pins & Needles in legs	☐ Fainting	☐ Neck Pain
☐ Pins & Needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Buzzing in Ears	☐ Ringing in Ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Neck stiff	☐ Cold Hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Problem Urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

List any medications you are 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 mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brothers _____

Sisters _____

Others _____

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

_____ _____

Signature Date