

General Information

Name _____ Birthdate ____/____/____ Age _____ Today's date ____/____/____

Address _____ City _____ State _____

Zip _____ Soc. Sec. # _____ - _____ - _____ Driver's License # _____

Home # () _____ Work # () _____ Ext. _____ Fax # () _____

Beeper/Cellular # () _____ E-Mail Address _____

Occupation _____ Employer's Name _____

Employer's Address _____ City _____ State _____ Zip _____

____ Male ____ Female # of Kids _____ ____ Single ____ Married ____ Divorced ____ Widowed

Name of Spouse _____ Names of Kids _____

Reason for consulting our office?

Referred by _____

**Please check if you are here for any of the following: ____ Motor Vehicle Accident ____ Work Injury ____ Other Injury

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 your true health potential.

The Beginning Years - Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

Birth History - Please check those items that apply to you

Mother smoked/drank/drugs in pregnancy Epidural/Meds in labor Breech Vaginal Delivery
 C-Section
 Forceps Delivery Vacuum Extractor used Labor Induced
 Complications
 Other _____

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

Childhood Illness Serious Falls Active in Sports
 Very Inactive
 Car Accident(s) Surgery/Stitches Alcohol/Drug Abuse
 Smoker
 Antibiotics/Other Meds Vaccinated Under Chiropractic care
 Broken Bones
 Severe Emotional Trauma(s) _____

Adult Years (Age 18 to present) - Please check those items that apply to you

Present Smoker Former Smoker OTC/Prescription Meds
 Alcohol Use
 Surgery/Stitches Play Sports Car Accidents
 Work Injury
 High Job Stress High Personal Stress Sit a lot
 Drive a lot
 Poor Sleep Not Enough Sleep Poor/Inadequate Diet
 No Exercise
 Flat Feet Wear Orthotics/Lifts Severe Health Problems
 Hard Falls
 Broken Bones Other _____

Injuries

Have been under chiropractic care in the past - How long ago was your last adjustment?

(Over Please)

Addressing the issues that brought you to our office

**If you have no symptoms or complaints and you are here for wellness care, please check here "Wish to have Chiropractic Wellness Services" and skip to "Family Health Profile" near the bottom of this form. Otherwise, please continue.

Chief Complaint(s):

How has this affected your life?

If you have pain, is it... Sharp Dull Constant Intermittent
 Traveling Radiating
 Intolerable Mild Moderate Moderately Severe Severe

Since it began, is it... About The Same Getting Better Getting Worse
 Variable

What makes it worse?

What makes it better?

Does it interfere with... Work Sleep Walking Sitting Exercise Hobbies
 Leisure Activities

Did you have an injury? Yes No If Yes, please explain _____

How long have you had this problem?

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

Other doctors/treatments you've tried for this problem (Please list): _____

Chiropractor _____

Medical Doctor _____

Other _____

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Pins & Needles in Legs/Feet | <input type="checkbox"/> Recurring Infection |
| <input type="checkbox"/> Infertility/Impotence/Miscarriage | | |
| <input type="checkbox"/> Pins & Needles in arms | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Back Stiffness/Pain |
| <input type="checkbox"/> Loss of Balance | | |
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Buzzing/Ringing in ears | <input type="checkbox"/> Sinus Problems/Allergies |
| <input type="checkbox"/> Nervousness/Anxiety | | |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Stomach Upset | | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability/Mood Swings |
| <input type="checkbox"/> Tension/Stress | | |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Neck Stiffness/Pain | <input type="checkbox"/> Cold Hands |
| <input type="checkbox"/> Cold feet | | |
| <input type="checkbox"/> Diarrhea/Constipation/Gas | <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Hot Flashes | | |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Problems Urinating |
| <input type="checkbox"/> Heartburn/Reflux | | |
| <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Pre-Menstrual Syndrome (PMS) | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Ulcers | | |
| <input type="checkbox"/> Jaw/TMJ Problems | <input type="checkbox"/> Other | |
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Family Health Profile - In our office, we are not only interested in your health & well being, but also in that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Parents _____

Siblings _____

Others _____

Have you ever:

Bought Bottled Water? Yes No

Belonged to a Health Club? Yes No

Consumed Vitamins or Supplements? Yes No

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 examine me for further evaluation.

Signature

____/____/____
Date