



Personal Information:

NAME: _____ PATIENT #: _____ AGE: _____ DATE: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE #: _____ WORK PHONE #: _____ CELL#: _____

EMAIL ADDRESS: _____ MALE _____ FEMALE _____

BIRTH DATE: _____ BEST TIME & NO. TO CONTACT: _____

OCCUPATION: _____ EMPLOYER'S NAME & ADDRESS: _____

SINGLE: _____ MARRIED: _____ PARTNERED: _____ DIVORCED: _____ WIDOWED: _____

OF CHILDREN: _____ NAMES, AGES & GENDER: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Your Health Profile:

Why This Form Is Important

As a Creating Wellness Center, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your health potential.

Addressing what brought you to this office.

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History" section (next page).

Others, please briefly describe your chief complaint, including the effect it has had on your life.

Health Concerns: List health concerns according to their severity	Rate of Severity 1 = mild 10 = worst imaginable.	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

If you are experiencing pain, is it: Sharp Dull Ache

Does the pain travel/radiate anywhere: No Yes – please describe (from where to where)

Since the problem started, it is ... About the Same Getting Better Getting Worse

What makes it worse? _____

What have you done for this condition that has helped you feel better? _____

What have you done for this condition that was of no help? _____

I Do I Do Not have a family history of this or similar symptoms (if you do, please explain)

Is this condition interfering with your: Work Leisure Sleep Sports/Exercise/Walking

Positive Mental Attitude Hobbies Other _____

Have you had to, or felt the need to make an "positive" changes in your life due to your condition? (i.e. eat better, less alcohol or drugs, meditate, less destructive sports, activities, etc.) If so what?

Other Doctors seen for this condition: Chiropractor Medical Dr. Other

1. Name/Address: _____

Date: _____ What was the diagnosis? _____

What was done? _____

2. Name/Address: _____

Date: _____ What was the diagnosis? _____

What was done? _____

General History:

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"/> Pins & Needles In Legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Pins & Needles In Arms | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Ringing In Ears | <input type="checkbox"/> Nervousness |
| <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 | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Urinary Problems | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers |

List any medications you are taking and why (**prescriptions** and **non-prescriptions**): _____

Have you had surgery? (Please include all surgeries)

1. Type: _____ Date: _____ Doctor: _____
2. Type: _____ Date: _____ Doctor: _____
3. Type: _____ Date: _____ Doctor: _____
4. Type: _____ Date: _____ Doctor: _____

Accidents and/or injuries: auto, work related or other (especially those related to your present problems)

1. Type: _____ Date: _____ Hospitalized: Yes No
2. Type: _____ Date: _____ Hospitalized: Yes No
3. Type: _____ Date: _____ Hospitalized: Yes No

Have you ever had x-rays taken? (If yes) When: _____ Where: _____

Area of body: _____

Do you wear orthotics or heel lifts? Yes No

Please list your top three stresses in each category:

1. Physical stress (falls, accidents, work postures, etc.)
 - a. _____
 - b. _____
 - c. _____
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, etc.)
 - a. _____
 - b. _____
 - c. _____
3. Psychological stress (work, relationships, finances, self-esteem, etc.)
 - a. _____
 - b. _____
 - c. _____

The Beginning Years

Research is showing that many of the health challenges that occur later in life originated during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Birth to 17 years of age	Yes	No	Unsure
Did you have any serious childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you take/use any drugs (prescribed or not)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you involved in any car accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there prolonged use of medicine such as Antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you suffer any other traumas? (Physical or Emotional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you under regular Chiropractic Care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Adult (18 to present):

	Yes	No
Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do/did you drink alcohol (more than socially)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Do you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>
Do/did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>

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

Occupational: _____

Personal: _____

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating Habits: _____ Exercise Habits: _____ Sleep: _____

General Habits: _____ Mind-set: _____

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 their names and any health conditions or concerns they may have:

Children: _____

Spouse/Partner: _____

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Others: _____

Have you ever:

Bought bottled water:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Belonged to a health club:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Consumed vitamins or supplements:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If there is a need for dietary changes or nutrients would like to be informed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If there is a need for specific exercises would you like to be informed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If there is a need for support in the psychological/mind/body/stress dimension of health would you like to be informed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I consent to a professional and complete chiropractic examination including any photography, scans, and assessments that the doctor deems necessary. I understand today's services are \$195.00 which includes a second "Report of Findings" appointment. We accept major medical insurance (please verify your benefits) Cash, Checks, and Credit Cards.

Signature: _____ Date: _____

