



PERSONAL INFORMATION:

Name: _____ Age: _____ Date: _____

Address: _____ City/State/ Zip: _____

Home Phone #: (____)____-____ Work Phone #: (____)____-____ Cell Phone #: (____)____-____

Email Address: _____ Male _____ Female: _____ DOB: _____

Occupation: _____ Employer Name And Address: _____

Best Time To Contact: _____ Status: Single Married Divorced Widowed

of Children, Names and Ages: _____

YOUR HEALTH:



Please place an "X" on the scale above marking where you believe your level of health and wellness is at this time. Place a circle (o) on the diagram indicating where you would **like** your health and wellness to be.

YOUR HEALTH PROFILE:

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History" page.

Health Concerns:	Rate Severity 1 = mild 10= worst imaginable	When did this start?	Are symptoms Constant or intermittent?	Did problem begin with injury?
-------------------------	---	----------------------	--	--------------------------------

Since the problem started, it is... ___The Same ___Getting Better ___Getting Worse
What makes the problem worse? _____

What, if anything makes it feel better? _____

Does this interfere with your: ___Work ___Leisure ___Sleep ___Sports ___Other: _____

Have you seen other doctors for this condition? ___Chiropractor ___ Medical Dr. ___Other

Name/ Address: _____

Date: _____ What was diagnosis? _____

Name/ Address: _____

Date: _____ What was diagnosis? _____

General History:

List all medications you are taking and why: (Prescription and non-prescription) _____

Have you had any surgeries or hospitalizations? (Please include all surgeries) _____

What do you do for a living? _____

Have you ever had any work related injuries? _____

Have you ever had any slips, falls or auto accidents? _____

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 and needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Pins and 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"/> |
| <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"/> Lights bother eyes | <input type="checkbox"/> Urinary Problem | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers |

Stomach Upset

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 Health: _____ Mind-set: _____

YOUR GOALS: At our office we concern ourselves with YOUR health and YOUR wellness goals. Please list your goals for your health and wellness in the spaces provided.

Physical Goals:

Nutritional/ Biochemical Goals

Psychological Goals

Have you ever:

Bought bottled water:

Yes No

Belonged to a health club:

Yes No

Consumed vitamins or supplements

Yes No

If there is a need for dietary changes would you like to know?

Yes No

If there is a need for specific exercises would you like to know?

Yes No

If there is a need for support in the psychological/mind/body/stress dimension of health would you like assistance?

Yes No

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: _____

Thank you for filling out this form. It is your first step to Creating Wellness!
Return this to our staff and someone will be right with you.

