

Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Residence and mailing City State Zip Code  
 Home Telephone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Driver's Lic.# \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Occupation/Employer's Name and address \_\_\_\_\_  
 Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Spouse's Occupation/Employer \_\_\_\_\_  
 No. of children: \_\_\_\_\_ (In Canada) Health Card# \_\_\_\_\_ Version Code: \_\_\_\_\_  
 Reason for consulting our office? \_\_\_\_\_  
 Who may we Thank for referring you 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.

### YOUR CHILDHOOD YEARS

	YES	NO	UNSURE		YES	NO	UNSURE
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was there any prolonged use of medicine such as antibiotics or an inhaler?	<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 suffer any other traumas (physical or emotional)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you take / use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	As a child, were you under regular Chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Have you fallen / jumped from a height over three feet? (i.e. crib, bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_

### ADULT - (18 TO PRESENT)

	YES	NO		YES	NO
Do / did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Do / did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>
Do / did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Do / did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	On a scale of 1 - 10 describe your stress level: (1 = none / 10 = Extreme)		
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Occupational _____		
			Personal _____		

On a scale of Poor, Good, Excellent describe your:  
 Diet \_\_\_\_\_ Exercise \_\_\_\_\_ Sleep \_\_\_\_\_ General Health \_\_\_\_\_

## Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here \_\_\_\_\_ "Wish to have Chiropractic Wellness Services" and skip to "Family Health Profile." Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

If you are experiencing pain, is it...

- Sharp       Dull       Comes and goes       Travels       Constant

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

What makes it worse: \_\_\_\_\_

Yes, it interferes with:       Work       Sleep       Walking       Sitting       Hobbies       Leisure

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.

- |   |   |   |  |
|---|---|---|--|
| <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"/> 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"/> Neck stiff               | <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"/> Problem Urinating      | <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 \_\_\_\_\_

### 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 \_\_\_\_\_

Have you ever:

- Bought bottled water:       YES       NO  
Belonged to a health club:       YES       NO  
Consumed vitamins or supplements:       YES       NO

*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:*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

