First Name: _____ MI_____ Last Name_____ Date: _____

Prefer to be called: _____ Address: _____

Home Phone #: _____ City & State: _____ Zip: _____

Cell Phone / Pager #: _____ E Mail: _____ Date of Birth: _____

( ) male ( ) female S.S. #: _____ Marital Status: S M D W No. of children: ___ Spouse' Name: _____

Occupation: _____ Employer: _____ Work Phone #:_____ ext._____

Have you ever received a Chiropractic Adjustment? _____ How long ago? _____ By whom? _____

Please tell us who referred you to our office. _____

YOUR HEALTH PROFILE

The focus in our office is your health. Our goals are, first, to address the issues that brought you to our 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 changes that have occurred and ultimately may challenge your health potential.

YOUR CHILDHOOD YEARS

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.

Yes	No	Not Sure		COMMENTS:
____	____	_____	Was your birth very difficult? (Forceps, cesarean, breach, with drugs)	_____
____	____	_____	Did you have childhood illnesses?	_____
____	____	_____	Did you have any serious falls or injuries?	_____
____	____	_____	Did you play youth sports?	_____
____	____	_____	Did you take / use any drugs?	_____
____	____	_____	Any side effects?	_____
____	____	_____	Did you have any surgery?	_____
____	____	_____	Any side effects?	_____
____	____	_____	Was there any prolonged use of medicine such as antibiotics or an inhaler?	_____
____	____	_____	Were you involved in physical accidents?	_____
____	____	_____	Did you suffer from any other traumas (physical or emotional)?	_____
____	____	_____	Were you vaccinated?	_____
____	____	_____	Were you seeing a chiropractor regularly?	_____

ADULT (18 – present)

Yes	No		
____	____	Did / do you smoke?	_____
____	____	Did / do you drink alcohol?	_____
____	____	Have you had any accidents?	_____
____	____	Have you had any surgeries?	_____
____	____	Did / do you play any adult sports?	_____
____	____	Did / do you participate in any extreme sports?	_____
____	____	Did / do you take any prescriptive drugs?	_____
____	____	Non prescriptive drugs?	_____
____	____	Any side effects?	_____

Addressing the Issues That Brought You to Our Office

Please briefly describe the chief area of complaint and the effect is having on your life.

_____

_____

_____

If you have no symptoms or complaints, and are here for wellness services, please check here:
_____ "I wish to have Chiropractic Wellness Care" and skip to "Family Health Profile".

If you are experiencing pain, is it …

____ Sharp ____ Dull ____Comes & goes ____ Constant ____ Travels

Since the problem started, it is… ____ getting worse ____ getting better ____ about the same

When did it start? _____What makes it worse? _____ Better? _____

It interferes with: ____ Work ____ Sleep ____Walking ____ Sitting ____ Hobbies ____ Leisure ____ Other _____

Please list any other doctors seen for this problem: _____

List any medications you are taking: _____

Please mark "1" for current symptoms, "2" for recent symptoms, and "3" if you have ever experienced the following symptoms.

____ Headaches	____ Pins & Needles in legs	____ Fainting	____ Neck Pain
____ Pins and Needles in arms	____ Loss of smell	____ Back Pain	____ Loss of balance
____ Dizziness	____ Buzzing in ears	____ Ears ringing	____ Nervousness
____ Numbness in fingers	____ Numbness in toes	____ Loss of taste	____ Upset stomach
____ Fatigue	____ Depression	____ Irritability	____ Tension
____ Problems Sleeping	____ Stiff Neck	____ Cold hands	____ Cold feet
____ Diarrhea	____ Constipation	____ Fever	____ Hot flashes
____ Cold sweats	____ Lights bother eyes	____ Urination problems	____ Heartburn
____ Mood swings	____ Menstrual Pain	____ Menstrual Irregularity	____ Ulcers

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

Diet _____ Exercise _____ Sleep _____ General Health _____

On a scale of 1 – 10, describe your stress level (1 = none, 10 = extreme): Occupational _____ Personal _____

Is there a family history of:
Heart Disease Arthritis Cancer Diabetes Other _____

Family Health Profile

We are also interested in the health and well being of your family and loved ones. Please use the space below to share any health concerns and conditions.

Children _____
Spouse _____
Parents _____
Siblings _____
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.

_____ _____
Signature Date