

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 office? _____

Who may we Thank for referring you to our office? _____

YOUR HEALTH PROFILE



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 experienced 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 profiles of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.



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 inhale?	<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?	<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 have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?	<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"/>	As a child, were you under regular Chiropractic care?	<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 accident?	<input type="checkbox"/>	<input type="checkbox"/>	On a scale of 1 – 10 describe your stress level: (1 = none / 10 = Extreme)	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Occupational _____		
			Personal _____		

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, is it ... 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"/> Pin and needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Pin 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"/> Cold Feet |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Light bother eyes | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual Irregularity | |

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 you may have about you:

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