NAME: AGE: DOB: / / ***SS#*** DATE:

ADDRESS: CITY: STATE: ZIP CODE:

HOME PHONE# CELL#

E-MAIL ADDRESS:

MALE: FEMALE: HEIGHT: WEIGHT: BLOOD PRESSURE:

OCCUPATION: EMPLOYER'S NAME AND PHONE #:

SINGLE: MARRIED: **SPOUSES NAME**: DIVORCED: WIDOWED:

NO OF CHILDREN: NAMES, AGES AND GENDER:

Insurance provider and ID:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

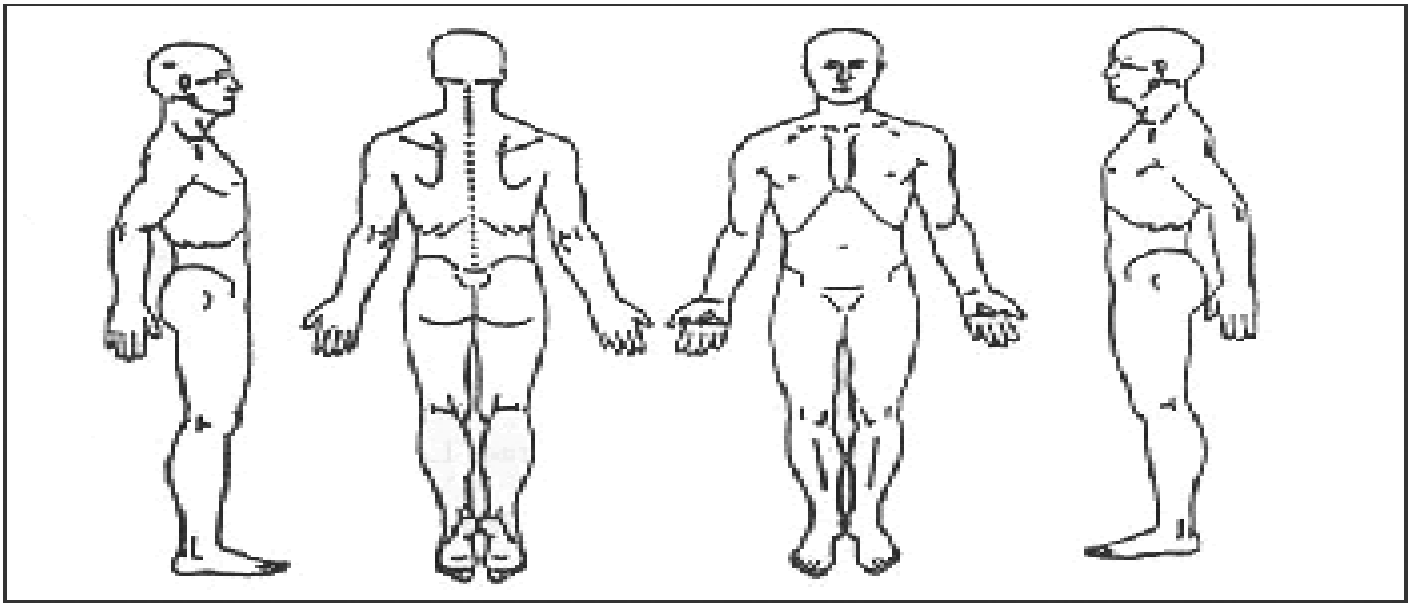
Your Health Profile

Addressing what brought you to this office

Please briefly describe your chief concern, including the effect it has had on your life.

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

Please circle your area(s) of complaint.



Place a letter corresponding to your pain description next to each area indicated
Ex. Sharp/stabbing=S Dull ache=D Tingling=T Burning =B Numb=N Stiff=ST Other, describe

Does the pain travel/radiate anywhere: □no □yes - please describe for each condition.

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? _____

Do you have a family history of this or similar symptoms □Yes □No (if yes, please explain) _____

Is this condition interfering with your: □Work □Leisure □Sleep □Sports/exercise/walking, □Positive mental attitude □Hobbies □Other _____

Please list 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:

- □ Headaches
- □ Pins and needles in legs
- □ Fainting
- □ Neck pain
- □ Pins & needles in arms
- □ Loss of smell
- □ Back Pain
- □ Loss of balance
- □ Dizziness
- □ Buzzing in ears
- □ Ringing in ears
- □ Nervousness
- □ Numbness in fingers
- □ Numbness in toes
- □ Loss of taste
- □ Stomach Upset
- □ Fatigue
- □ Depression
- □ Irritability
- □ Tension
- □ Sleeping problems
- □ Stiff Neck
- □ Cold Hands
- □ Cold Feet
- □ Diarrhea
- □ Constipation
- □ Fever
- □ Hot Flashes
- □ Cold Sweats
- □ Lights bother eyes
- □ Urinary Problem
- □ Heartburn
- □ Mood Swings
- □ Menstrual Pain
- □ Menstrual Irregularity
- □ Ulcers

Other conditions/diseases you would like the doctor to be informed of: _____

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

Have you had any surgery? (Please include all surgery)

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 How long:

2. Type: Date: Hospitalized □Yes □No How long:

3. Type: Date: Hospitalized □Yes □No How long:

Have you ever had x-rays or other imaging studies taken? (If yes) When: _____ where: _____Area of body: _____

_____

1. Physical stress (falls, accidents, work postures, etc.)
a._____
b. _____
c. _____

2. Bio-chemical stress (work chemicals, unhealthy foods, missed meals, don't drink enough water, drugs, mold etc.)
a. _____
b. _____
c. _____

3. Psychological stress (work, relationships, finances, self-esteem, family issues, etc.)
a. _____
b. _____
c. _____

Goals for care _____

Adult-(18 to present)

Do you smoke? □Yes How long _____ □No □Quit_____ years ago

Do you drink alcohol □Yes □No If yes how often? _____ How much? _____

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: Commitment to your health:

Family History

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: _____

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Others: _____

I consent to professional and complete chiropractic care and 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: _____