



Your Health Profile

Personal Information

NAME: _____ PATIENT#: _____ AGE: _____ SOC.#: _____ DATE: _____

ADDRESS: _____

CITY / STATE / ZIP: _____

HOME PHONE #: _____ WORK PHONE#: _____ CELL#: _____

E-MAIL ADDRESS: _____ MALE _____ FEMALE _____

BIRTH DATE: _____ BEST TIME & NO. TO CONTACT: _____

OCCUPATION _____ EMPLOYER'S NAME AND ADDRESS: _____

SINGLE: _____ MARRIED: _____ DIVORCED: _____ WIDOWED: _____ SPOUSE'S NAME: _____

NO OF CHILDREN: _____ NAMES, AGES AND GENDER: _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Your Health Profile

Why This Form Is Important

As a Creating Wellness Center, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your health potential.

Addressing what brought you to this office

If you have no symptoms or complaints and are here for **Chiropractic Wellness Services**, please skip to the "General History." (next page)

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

Health Concerns: <i>List health concerns according to their severity.</i>	Rate of Severity 1= mild 10= worst imaginable	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

If you are experiencing pain, is it...

Sharp Dull ache

Does the pain travel/radiate anywhere: no yes - please describe

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? _____

I do do not have a family history of this or similar symptoms (if you do, please explain)

Is this condition interfering with your: Work Leisure Sleep Sports/exercise/walking,

Positive mental attitude Hobbies Other _____

Have you had to, or felt the need to make any "positive" changes in your life due to your condition? (i.e., eat better, less alcohol or drugs, meditate, less destructive sports, activities, etc.) if so what?

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:

- | | | | |
|---|---|---|--|
| <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"/> 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 |

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 | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 2. Type _____ | Date _____ | Hospitalized | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 3. Type _____ | Date _____ | Hospitalized | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

Have you ever had x-rays taken? (if yes) When _____ Where _____

Area of body: _____

Do you wear orthotics or heel lifts? Yes No

Please list your top three stresses in each category:

1. Physical stress (falls, accidents, work postures, etc.)

- a. _____
- b. _____
- c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, etc.)

- a. _____
- b. _____
- c. _____

3. Psychological stress (work, relationships, finances, self-esteem, etc.)

- a. _____
- b. _____
- c. _____

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 list below their names and any health conditions or concerns they may have:

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

If there is a need for dietary changes or nutrients would you like to be informed? Yes No

If there is a need for specific exercises would you like to be informed? Yes No

If there is a need for support in the psychological/mind/body/stress dimension of health would you like to be informed? Yes No

➤ On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/psychological/lifestyle stress levels:

Scale = ____ Occupational stress: _____

Scale = ____ Personal stress: _____

➤ On a scale of 1 to 10 (1 = poor, 10 = excellent), describe your habits and condition as it relates to:

Eating ____ Exercise ____ Sleep ____ General Health ____ Wellness lifestyle ____

Rate your health and wellness.

Place an 'X' that denotes where you believe is your current level of wellness.

Place an 'O' indicating where you would like your wellness to be.



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.