Patient No.: ______________

Confidential Patient Information

Name: ____ **Age:** ________________ **Male** ☐ **Female** ☐

Social Security#: ______________________________________ **Date of Birth:** ________________________________

Single ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Spouse's name:** ___________________________________

Number of Children: ________________ **Occupation:** ____

Employer: ___________________________________ **Work Telephone:** ______________________________________

Home Telephone: ___________________________________ **Cell Phone:** ____________________________________

Mailing Address: ____

Work/ Local Address: ____

Email Address (or other contact info): ____

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. 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.

CHILDHOOD YEARS (up to age 17)

	Yes	No		Yes	No
Did you have any childhood illnesses?	☐	☐	Was there any prolonged use of medicine?	☐	☐
Have you fallen/ jumped from a height over 3 feet? (i.e. crib, bed, tree)	☐	☐	Did you suffer from any other physical/ emotional traumas?	☐	☐
Did you take/ use drugs? (Pharmaceutical or recreational)	☐	☐	Were you under regular chiropractic care as a child?	☐	☐
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	Were you involved in any car accidents as a child?	☐	☐
Were you vaccinated?	☐	☐	Did you play youth sports?	☐	☐

ADULT (18 years old to present)

	Yes	No		Yes	No
Do/ did you smoke?	☐	☐	Do/ did you play adult sports?	☐	☐
Do/ did you drink alcohol?	☐	☐	Do/ did you play extreme sports?	☐	☐
Have you had any surgery?	☐	☐	Have you been in any accidents?	☐	☐

On a scale of 1- 10, describe your stress level, (1= none/ 10= extreme): Occupational _________ Personal __________

Describe with Poor, Good, Excellent: Diet _________ Exercise __________ Sleep __________ General Health _________

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

Patient No.: _______________

❒ **If you have NO SYMPTOMS or COMPLAINTS, and are only here for wellness services, please check here.**
(If you are in pain, and need specific attention for certain problems, please continue with the rest of this page.)

What is your main reason for consulting our office today? ____

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? ____

It interferes with:

□ Work□ Sleep □ Walking □ Sitting □ Hobbies □ Leisure

Please list any other doctors seen for this problem:

____

Please check all symptoms related to your injury, or any that you suffer from on a regular basis (not necessarily connected with your injury).

□ Headaches	□ Pins/ 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	□ Neck stiffness	□ Cold hands	□ Cold feet
□ Diarrhea	□ Constipation	□ Fever	□ Hot flashes
□ Cold sweats	□ Light sensitivity	□ Problem urinating	□ Heartburn
□ Mood swings	□ Menstrual irregularity	□ Menstrual pain	□ 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 family members or 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:** ____________________