Your Health Profile

Patient Name____ Date_____________

Why This Form is Important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, 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. Please answer the following:

Physical Stress

Was YOUR birth traumatic? Yes ❍ No ❍

What sports did you play in school?

____

Did you have serious childhood falls or traumas?

____

____

Any auto accidents (even minor)?

____

____

Any other serious falls or injuries?

____

____

Have you had surgery (please list)?

____

____

Have you had a fracture or broken bone? Area?

____

____

Emotional Stress

At what age were you for the your 3 most impactful emotional stresses?

____

On a scale of 1-10, what would you rate an average day of stress in your life? __________

Where in your body do you hold or carry your stress?

____

Chemical Stress

Were you vaccinated? Yes ❍ No ❍

Has there been any prolonged use of medication? Yes ❍ No ❍

What are your current medications?

____

____

____

Do you smoke? Yes ❍ No ❍

Do you drink alcohol or caffeine on a daily basis? Yes ❍ No ❍

What Brought You Into Our Office?

If you have no symptoms or complaints and are here for wellness services, please check here____ .

Chief Complaints____

____

If you are experiencing pain it is....

❍ Sharp ❍ Dull ❍ Comes & Goes ❍ Travels
❍ Constant

Since the problem started, it is.....

❍ Getting Better ❍ About the same
❍ Getting Worse

What makes it worse?______________________________

____

The pain interferes with: ❍ Work ❍ Sleep

❍ Walking ❍ Sitting ❍ Hobbies ❍ Socializing
❍ Personal Care ❍ Lifting ❍ Reading
❍ Concentration ❍ Driving ❍ Sex Life

Please list other practitioners you have seen for this issue.

Chiropractor______________________________

Medical Doctor______________________________

Other______________________________

Please check all symptoms you have had, even if they do not seem to relate to your current problem.

General	❍ Allergies ❍ Dizziness ❍ Fainting ❍ Fatigue ❍ Headache ❍ Nervousness ❍ Depression ❍ Numbness or Tingling
Muscle & Joint	❍ Arthritis ❍ Bursitis ❍ Hernia ❍ Neck Pain/Stiffness ❍ Foot Trouble ❍ Wrist Pain ❍ Elbow Pain ❍ Shoulder Pain ❍ Arm Pain ❍ Hand Pain ❍ Mid Back Pain ❍ Rib Pain ❍ Hip Pain ❍ Knee Pain ❍ Chest Pain ❍ Leg Pain ❍ Low Back Pain ❍ Sciatica ❍ Ankle/Foot Pain ❍ Tail Bone Pain ❍ Spinal Curvature ❍ Swollen Joints
Gastro-Intestinal	❍ Diarrhea ❍ Belching/Gas ❍ Colitis ❍ Poor Digestion ❍ Constipation ❍ Diabetes ❍ Gallbladder ❍ Hemorrhoids ❍ Poor Appetite ❍ Pain Over Stomach
Eyes, Ears, Nose &Throat	❍ Asthma ❍ Deafness ❍ Ear Ache ❍ Ear Noises ❍ Eye Pain ❍ Enlarged Glands ❍ Thyroid Condition ❍ Sinus Infections
Cardio-Vascular	❍ High Blood Pressure ❍ Low Blood Pressure ❍ Poor Circulation ❍ Irregular Heart Beat ❍ Swelling of Ankles
Respiratory	❍ Chest Pain ❍ Chronic Cough ❍ Difficult Breathing
Skin	❍ Acne ❍ Bruises Easily ❍ Varicose Veins
Genito-Urinary	❍ Bed Wetting ❍ Unable to Control Urine ❍ Kidney Infections/Stones ❍ Painful Urination ❍ Prostate Problems
Women Only	❍ Menstrual Cramps/Backache ❍ Excessive Flow ❍ Irregular Cycle ❍ I Am Currently Pregnant.

Your Health Beliefs

What tools have you used to try to reduce stress?

____

____

How do you support your health?

____

What bad habits do you need to release?

____

____

Do you know why the brain and nervous system are called the Master Control System? Yes ❍ No ❍