

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ / Male Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: ( ) \_\_\_\_\_ Work#: ( ) \_\_\_\_\_ Cell#: ( ) \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_

Email address: \_\_\_\_\_ Status: Single Married Divorced Widowed

# of Children: \_\_\_\_\_ Names and Ages: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer Name/Address: \_\_\_\_\_

## 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.



## YOUR HEALTH PROFILE

➤ What brings you into our office today?

Please briefly describe, including the impact it has had on your life. If you're only here for chiropractic wellness services please skip this part and go to "General History" on the next page.

Rate Severity (scale 1-10, 1 being mild) \_\_\_\_\_ When and how did this start? \_\_\_\_\_ Are symptoms constant or intermittent? \_\_\_\_\_

➤ Since the problem started it is; \_\_\_the same \_\_\_getting better \_\_\_getting worse

What makes the problem worse? \_\_\_\_\_

➤ What, if anything, makes the problem feel better? \_\_\_\_\_

➤ Does this interfere with your; \_\_\_Leisure \_\_\_Work \_\_\_Sleep \_\_\_Sports \_\_\_Other

➤ Have you seen other doctors for this condition? \_\_\_Chiropractor \_\_\_MD \_\_\_Other

Name/Address: \_\_\_\_\_ Date: \_\_\_\_\_

What was the diagnosis: \_\_\_\_\_



GENERAL HISTORY

➤ Please list all medications you are taking, and why; (Prescription and non-prescription)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

➤ Have you had any surgeries and/or hospitalizations? \_\_\_Yes \_\_\_No

If yes, briefly explain: \_\_\_\_\_  
\_\_\_\_\_

➤ Have you ever had any work related injuries? \_\_\_Yes \_\_\_No

If yes, briefly explain: \_\_\_\_\_  
\_\_\_\_\_

➤ Have you ever had any slips, falls or auto accidents? \_\_\_Yes \_\_\_No

If yes, briefly explain: \_\_\_\_\_  
\_\_\_\_\_

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"/> Buzzing in ears        | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Diarrhea      |
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Ringing in ears        | <input type="checkbox"/> Cold hands             | <input type="checkbox"/> Cold sweats   |
| <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Numbness in toes       | <input type="checkbox"/> Cold feet              | <input type="checkbox"/> Mood Swings   |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Depression             | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Numbness in fingers    | <input type="checkbox"/> Constipation           | <input type="checkbox"/> Urinary problem        | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Menstrual pain         | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Back pain     |
| <input type="checkbox"/> Sleeping problems      | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Eyes bothered by light | <input type="checkbox"/> Neck Pain     |
| <input type="checkbox"/> Tension                | <input type="checkbox"/> Hot flashes            | <input type="checkbox"/> Stomach upset          | <input type="checkbox"/> Stiff neck    |
| <input type="checkbox"/> Ulcers                 |   |   |  |

**YOUR GOALS**

➤ 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\_\_\_\_

At our office we're concerned about your health and wellness goals. Please take a moment to list your goals

<b>Wellness Goals</b>		
Be Fit. <i>(Physical)</i>	Eat Right. <i>(Nutritional)</i>	Think Well. <i>(Psychological)</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check all that are relevant.

Do you:

- Water - Drink ½ your body weight in ounces
- Exercise regularly
- Take vitamins or supplements

Would you like to know more about:

- Proper Nutrition and meal planning
- Proper exercise routines and techniques
- How to deal with LifeStyle stress

Thank you for filling out this form.  
It is your first step to Creating Wellness!



## Your Wellness History – Health Profile, page 4

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I consent to a professional and complete chiropractic examination, and to any radiographic examination that the doctor deems necessary. The films itself is part of the patient's permanent record and remains the property of this office.

Please feel free to discuss our fees which are payable when services are received unless special arrangements are made in advance. I clearly understand and agree that services rendered me are charged directly to me and that I am personally responsible for payment. Furthermore, I understand that if I ask to have insurance billed for services rendered to me, and they do not cover services as anticipated, I am personally responsible for any payment due. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

Patient's  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Guardian or Spouse's  
Signature \_\_\_\_\_ Date: \_\_\_\_\_

In case of emergency notify: \_\_\_\_\_

Relationship: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_

