Your Wellness History – Health Profile

Creating Wellness™

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, 1being 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: _____

Chappell Chiropractic:
A Creating Wellness
Center

3875 M-72 East
Acme, MI 49640
Tel (231) 938-3830
Fax (231) 938-3831

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.

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

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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

Wellness Goals

Be Fit. *(Physical)*	Eat Right. *(Nutritional)*	Think Well. *(Psychological)*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check all that are relevant.

Do you:	Would you like to know more about:
❑ Water - Drink ½ your body weight in ounces	❑ Proper Nutrition and meal planning
❑ Exercise regularly	❑ Proper exercise routines and techniques
❑ Take vitamins or supplements	❑ How to deal with LifeStyle stress

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

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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: _____

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