Your Wellness History – Health Profile



			-					
	umber:							
					_			
	Names and							
Jecupation:		Employe	name/A	aaress:				
Rate	your health Place an 'X' Place an 'O'	that denote	s where	-	-			
	0 - 50 Very Challenged	50 - ; Chall	75 lenged	75 - 100 Transition	100 - 125 Good	125 + Excellent		
lease briefly descr	into our office todalibe, including the i	mpact it has			re only here	for chiroprac	ctic wellness s	services
lease briefly descr ease skip this part		mpact it has l al History" on	the next	page.				
lease briefly descrease skip this part ate Severity (scale	ibe, including the i and go to "Genera	mpact it has la la History" on) When an	the next	page. d this start?	Are sympto	ms constant	t or intermitter	
lease briefly descrease skip this part ate Severity (scale Since the problem of the problem).	ibe, including the i and go to "General a 1-10, 1being mild m started it is;	mpact it has lal History" on) When an the same	the next	page. d this start?	Are sympto	ms constant	t or intermitter	
lease briefly descrease skip this part ate Severity (scale Since the problem // hat makes the problem // what, if anything	ibe, including the i	mpact it has la la History" on) When an the same	the next	page. d this start?	Are sympto	ms constant	t or intermitter	



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GENERAL HISTORY

> Please list all medications	you are taking, and why; (Pre	scription and non-prescription)	
Have you had any surgeried lf yes, briefly explain:	•		
> Have you ever had any wolf yes, briefly explain:	•		
Have you ever had any slip If yes, briefly explain:			
Please check all symptoms y	ou have ever had, even if the	ey 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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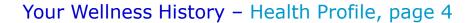


YOUR GOALS

On a	a scale of 1 to 10 (1 = none, 10 $\frac{1}{2}$) = extreme), describe	your emotio	nal/psychological/lifestyle stress levels	:	
	= Occupational stress:				_	
Scale	= Personal stress:				_	
➤ On	a scale of 1 to 10 (1 = poor, 10	= excellent), describe	e your habits	and condition as it relates to:		
Eating	Exercise Sle	eep General I	Health	Wellness lifestyle		
At our off	fice we're concerned about you	ur health and wellness	goals. Pleas	se take a moment to list your goals		
	Wellness Goals					
	Be Fit. (Physical) Eat Right. (lutritional)	Think Well. (Psychological)		
		_				
	Please check all that are r	relevant.				
<u></u>	<u>Do you</u> :		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 supplem	ents	☐ How to	deal with LifeStyle stress		

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







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 Spo	use's		
Signature		Date:	
In case of emergency notify:			
Relationship:	Address:		
Phone:			

