Last Name: _____First:_____ Sex: M / F Birth Date:_____/_____/_____
Spouse/Children: _____Today's Date_____/_____/_____
Whom may we thank for referring you to our office?_____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints and are here for wellness services, please check (√) here ☐ Others need to describe the major complaints, how and when did it start? Including the effect it has had on your life. **Please rate 0-10 with 10 being the worst.**

1._____0-10 =_____
_____
_____

2._____0-10 =_____
_____
_____

3._____0-10 =_____
_____
_____

4._____0-10 =_____
_____
_____

Circle the type of pain, is it… Sharp 1 2 3 4 Dull 1 2 3 4 Burning 1 2 3 4 Achy 1 2 3 4 Throbbing 1 2 3 4 Numb 1 2 3 4
Comes & Goes 1 2 3 4 Constant 1 2 3 4 Travels 1 2 3 4 The problem is Same 1 2 3 4 Getting better 1 2 3 4 Getting worse 1 2 3 4
What makes it better: 1_____2_____
3_____4_____
What makes it worse: 1_____2_____
3_____4_____
When it is at its worst, how does it feel? 1_____2_____
3_____4_____
Interferes with: Work 1 2 3 4 Sleep 1 2 3 4 Walking 1 2 3 4 Sitting 1 2 3 4 Hobbies 1 2 3 4 Leisure 1 2 3 4 Exercise 1 2 3 4
Has this occurred before? 1 Yes 2 Yes 3Yes 4Yes _____
What things /treatments have you tried: _____
_____

How important is it to you, to get these problems handled/resolved (*on a scale 0-10 with* **0** = not important **10** = the most important) **You are**_____
Any family member (s) have similar problems_____
Current Prescription Medication List:_____
Current Non-Prescription Medication List:_____
Vitamins/Supplements: _____
Hospital/Emergency Room visits:_____ Prior Surgery:_____
Anything you would change about your health or body: _____
_____
_____

Please check (√) all symptoms you have ever had, even if they do not relate to your current problem. C☐= Current, P☐= Past (1yr ago or more)

C☐ P☐ Headaches_____ C☐ P☐ Fatigue_____
C☐ P☐ Loss of Memory_____ C☐ P☐ Menstrual Problems_____
C☐ P☐ Dizziness_____ C☐ P☐ Hot Flashes_____
C☐ P☐ Visual Disturbances_____ C☐ P☐ Problem Urinating_____
C☐ P☐ Concussions_____ C☐ P☐ Kidney/Bladder Problems_____
C☐ P☐ Hearing Problems_____ C☐ P☐ Digestive Difficulties_____
C☐ P☐ Pain/Stiffness in Neck_____ C☐ P☐ Constipation_____
C☐ P☐ Tingling/Numb in Arms/Hands_____ C☐ P☐ Diarrhea _____

Name:_____Date_____/_____/_____

C☐= Current, **P**☐= Past (1yr ago or more)

C☐ P☐ Hand/Arm/Shoulder Problems_____
C☐ P☐ Back Pain_____
C☐ P☐ Tingling/Numb in Legs/Feet _____
C☐ P☐ Foot/Hip/Leg Problems_____
C☐ P☐ Broken/Fractured a Bone_____
C☐ P☐ Dislocated a Joint_____
C☐ P☐ Sleeping Problems _____
C☐ P☐ Depression/Mood Swing_____
C☐ P☐ Heart Problems_____
C☐ P☐ Cancer_____
C☐ P☐ Nightmares_____
C☐ P☐ Grind/Clench Teeth _____
C☐ P☐ Dental Problems_____
C☐ P☐ Brest Pain /Lumps_____
C☐ P☐ Infertility/Miscarriages_____
C☐ P☐ Hair Thinning or Loss_____
C☐ P☐ Co-ordination Problems_____
C☐ P☐ Restless Legs_____
C☐ P☐ Varicose Veins_____
C☐ P☐ Rashes /Hives_____
C☐ P☐ Postural Problems_____

C☐ P☐ Excessive Gas_____
C☐ P☐ Ulcers_____
C☐ P☐ Heartburn_____
C☐ P☐ Chest Pain_____
C☐ P☐ Difficulties Breathing_____
C☐ P☐ Respiratory Infections_____
C☐ P☐ Shortness of Breath_____
C☐ P☐ Asthma_____
C☐ P☐ Irritability_____
C☐ P☐ Attention Problems_____
C☐ P☐ Reading/ Learning Difficulties_____
C☐ P☐ TMJ_____
C☐ P☐ Weight Trouble_____
C☐ P☐ Prostate/Sexual Dysfunction_____
C☐ P☐ Decrease Sex Drive_____
C☐ P☐ Ringing in Ears_____
C☐ P☐ Frequent Colds_____
C☐ P☐ Cold hands/Feet_____
C☐ P☐ Sinus Problems_____
C☐ P☐ Allergies_____
C☐ P☐ Hemorrhoids_____

_____

_____

_____

Daily Activities: (Effects of current condition on performance) *Please check each appropriately*

	No Effect	Mild Pain (can do it)	Moderate Pain (limited)	Severe (unable to perform)
Bending:	☐	☐	☐	☐
Carrying Groceries:	☐	☐	☐	☐
Changing Positions(Sit to Standing):	☐	☐	☐	☐
Climb Stairs:	☐	☐	☐	☐
Driving:	☐	☐	☐	☐
Extended Computer Use:	☐	☐	☐	☐
Household Chores	☐	☐	☐	☐
Kneeling:	☐	☐	☐	☐
Lifting Children:	☐	☐	☐	☐
Lifting:	☐	☐	☐	☐
Reading(Concentrated):	☐	☐	☐	☐
Self Care(Bathing):	☐	☐	☐	☐
Self Care(Dressing):	☐	☐	☐	☐
Self Care(Shaving):	☐	☐	☐	☐
Sexaul Activities:	☐	☐	☐	☐
Sleep:	☐	☐	☐	☐
Sitting:	☐	☐	☐	☐
Standing:	☐	☐	☐	☐
Walking:	☐	☐	☐	☐
Yard Work:	☐	☐	☐	☐
Other_____:	☐	☐	☐	☐

Name:_____Date_____/_____/_____

Your Health Profile

Why This Form Is Important

As a Wellness Chiropractic office, we focus on your ability to be healthy. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health. Most times the effects are gradual not even seen until they become serious. Research is showing that many of the **health challenges that occur later in life have their origins during childhood**, some starting at birth. Answering the following questions will give us a profile of the specific stresses you have faced that caused your body to break down, allowing us to better assess the challenges to your health and what is required to regain your health.

Please answer the following Questions to the best of your ability.

Your Childhood Years	**Yes**	**No**	**Unsure**	
Childhood illnesses/Frequent colds/ear infections?	☐	☐	☐	
Prolonged medication antibiotics or inhaler?	☐	☐	☐	
Falls/injuries as a child? (i.e. crib, bunk bed, tree)	☐	☐	☐	
Surgeries, procedures or braces?	☐	☐	☐	
Physical or emotional abuse/trauma?	☐	☐	☐	
Were you involved in any car accidents as a child?	☐	☐	☐	
Difficult/ traumatic birth? (i.e. breech, forceps, vacuum)	☐	☐	☐	
Vaccine reactions (fever, seizures, personality changes)?	☐	☐	☐	

The following 3 areas can contribute to nerve interference and malfunction and diminish one quality of life. Circle the areas that apply to you when: **C=Child T=Teen A=Adult N=Never had (please circle)**

Physical Stress		**Emotional Stress**		**Chemical Stress**	
Difficult birth	C T A N	Relationships	C T A N	Environment	C T A N
Slip/Fall	C T A N	Career	C T A N	Smoker	C T A N
Car Accident	C T A N	Family	C T A N	Second Hand Smoke	C T A N
Sport Injury	C T A N	Money	C T A N	Sugar/Carbs	C T A N
Poor Posture	C T A N	Fast Pace Life	C T A N	Artificial Sweeteners	C T A N
Sitting on Wallet	C T A N	Hold Feelings In	C T A N	Prescription Drugs	C T A N
Stomach Sleeper	C T A N	Quick Temper	C T A N	Non Prescription Drugs	C T A N
Computer Work	C T A N	Perfectionist	C T A N	Recreational Drugs	C T A N
Prolonged Sitting	C T A N	Procrastinator	C T A N	Poor Diet	C T A N
Lack of Physical Activity	C T A N	Loss of a Love One	C T A N		
Excess Physical Activity	C T A N				

Previous Chiropractic care? ☐None, ☐ Regular, ☐Off & On, Reason:_____

	Yes	**No**	**Unsure**	
Accidents (auto, motorcycle, bike…)?	☐	☐	☐	
Falls, injuries (horse, skating, ladders…)?	☐	☐	☐	

What type of work do you do? _____ Satisfied/Enjoy your work? Yes ☐ No☐

What are your current play and relaxation activities_____

Sports played? as a child and adult _____

Do you smoke? _____ ☐ ☐ How long_____ How much_____

On a Scale of *Poor*, *Good*, or *Excellent* describe your: Diet _____ Sleep_____Exercise _____ General Health_____ **Yes No**

On a scale 0-10 describe your stress level: (0=none/10=extreme) Occupational____ Personal___Are you as healthy today as you were 5 yrs ago? ☐ ☐

Name:_____Date_____/_____/_____

Diet: Food, dyes or additives Allergies or Intolerances list: _____
Concerns about your diet? _____
What do you eat for breakfast? _____
For lunch? _____
For dinner? _____
For snacks?_____

How much water do you drink _____cups/day, How much coffee do you drink _____cups/day,
How much sports drinks /soda pop do you drink _____cups/day, Amount of alcohol weekly?_____

Family History: Cancer: yes☐ no☐, Heart Disease: yes☐ no☐, Diabetes: yes☐ no☐, Arthritis: yes☐ no☐, Parkinson's/Alzheimer :yes☐ no☐

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: Children_____
Spouse _____ Parents _____ Other _____

Signature:_____Date____/____/____ Dr's Signature_____

TERMS OF SERVICE

When a person seeks chiropractic care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. We also strive to inform you how minimize or manage physical, chemical and emotional stress that creates the subluxations.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine and extremities.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate wisdom/ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend you seek the services of a health care provider who specializes in that area. Regardless of what disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. If a lifetime of a better functioning body is what you want for you, your family, and friends, then welcome! You are in the right place.

I, (Printed name)_____ (Signature)_____undertake chiropractic services on the understanding of and agreement with, the above explanation. _____ (Date).

Consent to evaluate and adjust a minor and/or child: I, _____ (Print name) being the parent or legal guardian of _____(Print name) give permission for my child to receive chiropractic care.