CONFIDENTIAL PATIENT INFORMATION

First & Last Names____ Today's Date ____/____/______

DOB ___/___/_____ Age_____ Sex: Male Female (circle one) Marital Status______ Nick Name_________________

E-mail____

Address____City________________ State____ Zip__________

Phone: Home (_____) __________________Work(____)___________________ Cell (____) ____________________

Occupation____________________________________ Employer____

Guardian/Spouse's Full Name ____ Their phone (______)____________

Emergency Contact if different than above ________________________________ Their phone (______)___________

If insurance, person who carries insurance policy ____

Their relationship to patient _________________ Their DOB ____/_____/____ Their phone (______)____________

Their Address if different ____

Who can we thank for referring you to our office? ____

Does your visit today regard an injury as a result of ☐ Work injury? ☐ Car Accident? ☐Other injury? (check one)

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT: As a chiropractic office that centers on family wellness, we focus on helping you reach your optimum health potential. Our first goal is to address the issues, if any, that brought you here and eliminate any interference that is preventing you from reaching your maximum health performance. In addition, we hope to offer you and your family the opportunity for a lifetime of health and vitality. We all experience physical, chemical and emotional stresses that can accumulate and result in loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes when it's already too late. Your answers to the following questions will give us a general view of the stresses you have faced in your life. This will allow us to better assess your current health status and determine how to best serve your health goals.

THE BEGINNING YEARS – Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

BIRTH HISTORY – *Please check all that apply.*

☐ Mother smoked/drank/drugs during pregnancy ☐ Breech ☐ Vacuum Extractor Used
☐ C-Section ☐ Forceps Delivery ☐ Complications
☐ Other ____

CHILDHOOD YEARS (0-17 years) – *Please check all that apply.*

☐ Frequent childhood illness ☐ Serious Falls ☐ Active in sports ☐ Very Inactive
☐ Car Accident(s) ☐ Smoker ☐ Broken Bones ☐ Frequent Antibiotics
☐ Severe Emotional Trauma(s) ☐ Under Chiropractic Care
☐ Other ____

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HEALTH HISTORY –

Describe any operations you've had and the dates:____

Significant past injuries not already noted:____

Are you now taking any medication? ☐ No ☐ Yes What kind?____

____

Do you have any allergies?____

Do you smoke cigarettes ☐ Yes ☐ No If applicable, Are you pregnant? ☐ Yes ☐ No

How much exercise per week do you get?____

How would you rate your overall stress level? ☐ Low ☐ Medium ☐ High

What is your caffeine consumption if any? ____

How would you rate your nutritional habits? ☐ Poor ☐ OK ☐ Great

How many hours do you work/week? _______If children at home, how many?______ What are their ages?_______

Family history of cancer, diabetes, heart disease, rheumatoid arthritis, neurologic disorders? ____________________

____

Have you been under chiropractic care in the past? ☐ Yes ☐ No

If yes, how long ago was your last adjustment?____

****PLEASE MARK ALL RECURRING OR SEVERE SYMPTOMS YOU HAVE EXPERIENCED, EVEN IF THEY SEEM UNRELATED TO YOUR CURRENT PROBLEM. USE "C" FOR CURRENT, "P" FOR PAST**

☐ Headaches/Migraines	☐ Buzzing/ringing in ears	☐ Pain/Numbness in fingers, hands or arms
☐ Dizziness/vertigo	☐ Sinus Problems	☐ Pins & Needles in arms
☐ Jaw/TMJ Problems	☐ Loss of taste	☐ Loss of Smell
☐ Infertility/Impotence/Miscarriage	☐ Stomach Upset	☐ Diarrhea/Constipation/Gas
☐ Problems urinating	☐ Incontinence	☐ Other bowel issues
☐ Heartburn/Acid reflux	☐ Bladder Issues	☐ Pre-Menstrual Syndrome
☐ Pins & Needles in legs/feet	☐ Loss of balance	☐ Numbness in toes
☐ Vision disturbance	☐ High Blood Pressure	☐ Depression
☐ Recurring Infection	☐ Anxiety	☐ Fatigue
☐ Sleeping Problems	☐ Shortness of breath	☐ Other: ____________________________

ISSUES THAT BROUGHT YOU TO OUR OFFICE -

**If you have no symptoms or complaints and you are here for lifestyle care to optimize your health and peak performance, please check the box below and skip the following "Areas of Concern" Questionnaire.

☐ **WISH TO HAVE LIFESTYLE CARE**

Skip to statement signature portion on bottom of this form below.

☐ **I have a primary complaint(s) FOR WHICH I AM SEEKING CARE (Crisis Care)**

Please complete the following "Areas of Concern" Questionnaire regarding your primary complaints. After you have experienced relief and stability through crisis care, all patients have the option of lifestyle care to optimize their health and peak performance.

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to examine me for further evaluation.

____ ____/____/______

Signature (Of parent or guardian if patient is a minor) Date

First & Last Names____

What are the primary complaints for which you are seeking care?
PRIMARY COMPLAINT(S)____
____
How has this affected your life?____
____
____

Please list your complaints from most severe (1) to least severe (3). Use an additional form if needed.

	1	**2**	**3**	*Please do not write in this space*
You have the following physical complaints:	________________ ________________	________________ ________________	________________ ________________	
When did this start?	________________	________________	________________	
What makes it better?	________________ ________________	________________ ________________	________________ ________________	
What makes it worse?	________________ ________________	________________ ________________	________________ ________________	
Is this complaint: Sharp, Dull, Achy, Throbbing, Numb, shooting, or Other?	________________ ________________	________________ ________________	________________ ________________	
Does the pain radiate *(ex: into arms or legs?)* If so, describe.	________________ ________________	________________ ________________	________________ ________________	
On a scale of 1-10, rate your pain level: *(Circle One)*	0 1 2 3 4 5 6 7 8 9 10 *0 = no discomfort* *10= excruciating*	0 1 2 3 4 5 6 7 8 9 10 *0 = no discomfort* *10= excruciating*	0 1 2 3 4 5 6 7 8 9 10 *0 = no discomfort* *10= excruciating*	
How Often do you feel this complaint?	☐ Constant ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _________	☐ Constant ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _________	☐ Constant ☐ Daily ☐ Weekly ☐ Monthly ☐ Other _________	
Is it getting better, worse, or staying the same?	☐ Better ☐ Worse ☐ Same	☐ Better ☐ Worse ☐ Same	☐ Better ☐ Worse ☐ Same	
How have you taken care of this in the past?	________________ ________________	________________ ________________	________________ ________________	
Helping this issue would increase the quality of my life by:	☐ 0-25 ☐ 25-50% ☐ 50-75% ☐ 75-100%	☐ 0-25 ☐ 25-50% ☐ 50-75% ☐ 75-100%	☐ 0-25 ☐ 25-50% ☐ 50-75% ☐ 75-100%	

First & Last Names____

BODY DIAGRAM–

Please use the diagram at below to draw in any areas of complaint or concern. If no problem areas, please leave blank and sign and date below. Use these symbols if necessary:

XXX Sharp 000 Dull Ache /// Burning Pain ^^^Numbness *** Pins and needles or tingling

Left Side

Right Side

Right Side

Left Side

____ ____/____/______

Signature (Of parent or guardian if patient is a minor) Date