Name ________________________________ Age _______ Birth Date __________ Today's Date: ___________
Address _________________________________ City __________________ST _________ Zip _______________
Phone # (H)___________________ (O) _____________________Email _______________________________________
Sex M / F Social Security # ____-___-_____ Occupation ____
Marital Status ___________ Spouse Name __________________________ Spouse's Occupation____________
Of Children ___________ Names ____
Were you referred to this office? Y / N (if yes, by whom?) ____

YOUR HEALTH PROFILE

Research demonstrates that many of the health challenges that occur in life have their origins during the developmental years, some as early as birth. Please answer the following questions to the best of your ability.

CHILDHOOD YEARS (0-18 years)	**NO**	**YES**	If yes, please give dates and severity.
Did you have any childhood illnesses?	☐	☐	____________________
Did you have any serious falls as a child?	☐	☐	____________________
Did you take/use any drugs?	☐	☐	____________________
Did you have any surgery?	☐	☐	____________________
Did you fall/jump from a height over 3 feet?	☐	☐	____________________
Were you involved in any car accidents?	☐	☐	____________________
Was there any prolonged use of medicines?	☐	☐	____________________
(I.e. antibiotics, inhaler)			
Did you suffer any trauma? (Physical/emotional)	☐	☐	____________________
Were you vaccinated?	☐	☐	____________________
Did you receive regular Chiropractic care?	☐	☐	____________________

ADULT YEARS– (18 to present)			
Do / did you smoke?	☐	☐	____________________
Do / did you drink alcohol?	☐	☐	____________________
Have you been in any accidents?	☐	☐	____________________
Have you had any surgery?	☐	☐	____________________
Did / do you play sports?	☐	☐	____________________

On a scale of 1 – 10 rate your stress level

(1= none / 10 = extreme)

Occupational _____________Personal ________________

On a scale of *P*oor, *G*ood, *E*xcellent describe your:

Diet __________ Exercise __________ Sleep __________ General Health __________

HEALTH PROBLEMS

If you have no symptoms or complaints and are here for wellness services, please check (✔) here ☐
"I Wish to have Chiropractic Wellness Services" and skip to **"Family Health Profile."**

Please briefly describe the chief area of complaint, including the effect it has had on your life.
What is your (C/C) Chief Complaint/pain today and the *location* on your body? ____________________________________
____

How long have you been experiencing this discomfort? ____
____

What makes it better? ____
____

What makes it worse? ____
____

Other health care providers you have seen for this problem: ____
____

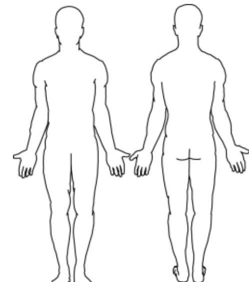
MEDICATIONS

List any medication you may have taken for this problem as well as ALL other meds you currently take. Please include any nutritional supplements. ____
____

HAVE YOU EVER SUFFERED FROM:

(Circle any that apply.)

Dizziness	Backaches	Allergies
Heart Trouble	Diabetes	Immune Weakness
Arthritis	Headache	Constipation
Asthma	Neuritis	Stress/Tension
Digestive Disorders	Nervousness	Depression
Sinus Trouble	Neck Pain	Fatigue
Cancer	Tumors	Female Health Challenges



Please denote your problem areas on the figures.

FAMILY HEALTH PROFILE

Please take the time to mention any health concerns you have for family members listed below.

Spouse ____

Children ____

Mother____

Father____

Brother(s) ____

Sister(s) ____

Others____

CONSENT AND AUTHORIZATION

The information and statements I have given on this form are accurate and to the best of my recollection. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment.

Patient's Signature ____ Date ________________

Parent/Guardian's Signature ____Date ________________