PERSONAL HEALTH PROFILE

Name:			Date:
Home address:		City:	Postal Code:
Email address:		Home Phone: ( )	Work Phone: ( )
Gender: M ☐ F ☐	Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Common Law ☐		Cell Phone: ( )
Date of Birth: MM DD YY	Age:	Occupation:	
Extended Health Insurance: Yes ☐ No ☐ Company:		$ Participation/Year:	Renewal Date:
How were you referred to our office?	Have you ever received chiropractic care before? Yes ☐ No ☐ Who was the doctor and where? # of years under care?		
Spouse's Name:	Spouse's Occupation:		
Do you have children? Yes ☐ No ☐	What are your children's names/ages?		If under 18, parents names are?
FEMALES ONLY Are you pregnant? ☐ Yes ☐ No	If yes, how many weeks?		Is this your first pregnancy? ☐ Yes ☐ No *(please indicate)* ___

PRESENT STATE OF HEALTH

Years of continuing damage show up as acute or chronic symptoms.

Is this visit for a wellness checkup? Yes ☐ No ☐ If this is for a specific concern, proceed below.

	Primary Concern	Secondary Concern
Specific concern (s) and location		
How long have you had this?		
How would you describe the pain?	☐ sharp ☐ dull/achy ☐ burn ☐ pins/needles	☐ sharp ☐ dull/achy ☐ burn ☐ pins/needles
How often does this happen	☐ constant ☐ daily ☐ on/off	☐ constant ☐ daily ☐ on/off
What makes it worse?		
At its worst, this problem interferes with?	☐ sleep ☐ family/social ☐ hobbies time ☐ work ☐ daily activities	☐ sleep ☐ family/social ☐ hobbies time ☐ work ☐ daily activities
What have you tried to address this concern?		

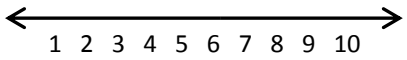
If you don't get a problem corrected, do you think it will get worse in the next

1 year ☐ 2 years ☐ 5 years ☐

Besides taking care of the above concerns, what is your greatest motive for wanting to get better/be healthier?

(eg. exercise, family, job, live longer, live easier)

On a scale of 1 to 10 (10 being the highest), rate your commitment to improving your health (circle number)



Not commited at all | somewhat committed | Highly committed

Let's begin at birth when you may have first damaged your nervous system, lost your wellness, and began a journey to ill health. How would you describe your birth, growth, and development?

Check off the following that describe your birth.

☐ long and/or difficult ☐ forceps ☐ vacuum extraction ☐ caesarean ☐ epidural
☐ breech ☐ induced ☐ natural (no drugs/pulling/excessive force) ☐ don't know

As a child, were you checked regularly by a chiropractor? Yes ☐ No ☐

TRAUMAS AND STRESSES

What are the FIVE most serious physical traumas/stresses that you've esperienced (eg. Automobile jarring/impacts, work stresses, recreational activities, sports, falls, fractures...etc.)

Trauma	Date of Trauma	Office Use
1)		
2)		
3)		
4)		
5)		

Mental/emotional stress levels (1 to 10, 10 being high): _____
Caused by: ☐ work ☐ family ☐ home ☐ other (please indicate)_____
Have you ever been hospitalized? If so, please describe

Have you had any surgeries? _____
Are you currently taking any medications? _____
What medications/chemicals have you taken in the last 5 years? _____
Have you had x-rays previously taken? If so, when? _____

Check off any of the following bodily warning signs that you have experienced in the past.

☐ Tension/headaches
☐ Mild back pain
☐ Neck pain
☐ Tension across top of shoulders
☐ Pain between shoulders
☐ Numbing/tingling in arms/hands
☐ Wrist/hand pain
☐ Chest pain
☐ Heartburn
☐ High/low blood pressure
☐ Elevated cholesterol
☐ Poor posture
☐ Dizziness
☐ Blurred/failing vision
☐ Deafness/ears ringing
☐ Earaches/ear infections
☐ Low back pain
☐ Numbing/tingling in legs/feet
☐ Hip pain
☐ Knee pain
☐ Foot pain
☐ Shin splints
☐ Arthritis/swollen joints
☐ Allergies/infections
☐ Digestive problems
☐ Ulcer
☐ Diabetes
☐ Bladder problems
☐ Thyroid problems
☐ Weight trouble
☐ Breathing problems
☐ Asthma
☐ Immune problems
☐ Frequent colds/flu
☐ Heart problems
☐ Difficulty sleeping
☐ Anxiety/depression
☐ Poor concentration/ memory
☐ Sexual dysfunction
☐ Infertility
☐ Cancer

Other health concerns: (**FEMALES ONLY)**

☐ Excessive cramping/pain
☐ Excessive menstruation
☐ Irregular cycle
☐ Hot flashes
☐ Breast pain/lumps