

PERSONAL HEALTH PROFILE

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

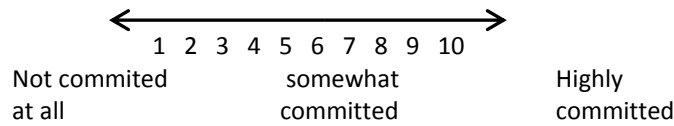
| | Primary Concern | Secondary Concern |
|----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------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



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 experienced (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.

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

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

- | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| <input type="checkbox"/> Excessive cramping/pain <input type="checkbox"/> Excessive menstruation <input type="checkbox"/> Irregular cycle | <input type="checkbox"/> Hot flashes <input type="checkbox"/> Breast pain/lumps |
|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|