

Since the problem started, it is... About the same Getting Better Getting Worse

What makes it worse? _____

What have you done for this condition that has helped you feel better? _____

What have you done for this condition that was of no help? _____

I do do not have a family history of this or similar symptoms (if you do, please explain)

Is this condition interfering with your: Work Leisure Sleep Sports/exercise/walking,

Positive mental attitude Hobbies Other _____

Have you had to, or felt the need to make any "positive" changes in your life due to your condition? (i.e., eat better, less alcohol or drugs, meditate, less destructive sports, activities, etc.) if so what?

Other Doctors seen for this condition: Chiropractor Medical Dr. Other

1. Name/Address: _____

Date: _____ What was the diagnosis? _____

What was done? _____

2. Name/Address: _____

Date: _____ What was the diagnosis? _____

What was done? _____

General History:

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Urinary Problem | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers |

List any medications you are taking and why: (**prescription** and **non-prescription**)

Have you had any surgery? (Please include all surgery)

| | | |
|---------------|------------|--------------|
| 1. Type _____ | Date _____ | Doctor _____ |
| 2. Type _____ | Date _____ | Doctor _____ |
| 3. Type _____ | Date _____ | Doctor _____ |
| 4. Type _____ | Date _____ | Doctor _____ |

Accidents and/or injuries: auto, work related, or other (especially those related to your present problems).

| | | | | |
|---------------|------------|--------------|------------------------------|-----------------------------|
| 1. Type _____ | Date _____ | Hospitalized | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Type _____ | Date _____ | Hospitalized | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Type _____ | Date _____ | Hospitalized | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you ever had x-rays taken? (if yes) When _____ Where _____

Area of body: _____

Do you wear orthotics or heel lifts? Yes No

Please list your top three current stresses in each category:

- Physical stress (falls, accidents, work postures, etc.)
 - _____
 - _____
 - _____
- Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, etc.)
 - _____
 - _____
 - _____
- Psychological stress (work, relationships, finances, self-esteem, etc.)
 - _____
 - _____
 - _____

The Beginning Years

Research is showing that many of the health challenges that occur later in life originated during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Birth to 17 years of age

| | Yes | No | Unsure |
|--|--------------------------|--------------------------|--------------------------|
| Did you have any serious childhood illnesses? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you have any serious falls as a child? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you play youth sports? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you take /use any drugs (prescribed or not)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you have any surgery? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Were you involved in any car accidents? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Was there prolonged use of medicine such as Antibiotics or an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you suffer any other traumas? (physical or emotional) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Were you vaccinated? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Were you under regular Chiropractic care? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

COMMENTS: _____

Adult-(18 to present)

| | YES | NO |
|--|--------------------------|--------------------------|
| Do/did you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do/did you drink alcohol (more than socially)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you been in any accidents? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you play any adult sports? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do/did you participate in extreme sports? | <input type="checkbox"/> | <input type="checkbox"/> |

On a scale of 1-10 describe your psychological/emotional stress levels: (1 = none/ 10=extreme)

Occupational: _____

Personal: _____

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating habits: _____ Exercise habits: _____ Sleep: _____

General Health: _____ Mind-set: _____

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 list below their names and any health conditions or concerns they may have:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Others: _____

Have you ever:

Bought bottled water: Yes No

Belonged to a health club: Yes No

Consumed vitamins or supplements Yes No

If there is a need for dietary changes or nutrients would you like to be informed? Yes No

If there is a need for specific exercises would you like to be informed? Yes No

If there is a need for support in the psychological/mind/body/stress dimension of health would you like to be informed? Yes No

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature _____ Date: _____

Thank you for filling out this form. It is your first step to **Creating Wellness!**
Return this to our staff and someone will be right with you.