Confidential Client Information

Name: ______________________________ Date: ______________________

Address: ____
Residence/Mailing City State Zip Code

Home Phone #: ________________ Work Phone #: ________________ Male Female

Email Address: ________________________ Date of Birth: ________________

Marital Status: S M W D Occupation: ____________________ Name of spouse: ________________

No. of Children: _____ Names & Ages: ______________________________

Who may we thank for referring you to our office? ________________________

What are your objectives in consulting this office? Wellness Preventative Care Other: ________________

If you'd like us to check if you have insurance coverage, please let us know.

Your Health Profile

Why is this form important

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved heath potential and wellness services. On a daily basis we experience, physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

In the Beginning (To Age 17)

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

	Yes	No	Unsure
Did you have a traumatic birth, premature, C-section, epidural, forceps or vacuum extraction?	☐	☐	☐
Did you have any childhood illnesses?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take/use any drugs?	☐	☐	☐
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you have any adverse reactions from vaccinations?	☐	☐	☐

	Yes	No	Unsure
Did you have any surgery as a child?	☐	☐	☐
Did you have any serious falls as a child or have you fallen/jumped from a height over 3 feet? (i.e. crib, bunk bed, trees)	☐	☐	☐
Did you suffer any other traumas (physical or emotional)?	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐
As a child, were you under regular Chiropractic care?	☐	☐	☐

Comments: ____

____

As an Adult (18 to present)

	Yes	No	Unsure
Do/did you smoke?	☐	☐	☐
Do/did you drink alcohol? ☐ 1-4/mo ☐ 1-4/week ☐ >2/wk	☐	☐	☐
Have you been in any accidents?	☐	☐	☐
Have you had any surgery?	☐	☐	☐
Do/did you play any adult sports?	☐	☐	☐

On a scale of 1-10, describe your stress level:
(1=none/10-extreme)
Occupational ____________
Personal ____________

On a scale of Poor, Good, Excellent, describe your:
Diet ____________
Exercise ____________
Sleep ____________
General health ____________

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

If you have no symptoms or complaints, and are here for wellness services, please check here ____ "Wish to have Chiropractic Wellness Services". Otherwise, please briefly describe your health challenge including the effect it has had on your life.

____

____

If you are experiencing pain, is it…

Sharp   Dull   Comes & Goes   Travels   Constant

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

Yes, it interferes with: Work   Sleep   Walking   Sitting   Hobbies   Leisure

What makes it worse? ____

Other doctors I've seen for this problem:

Chiropractor ___________________________

Medical Doctor _________________________

Other __________________________________

Please check all symptoms/problems you have ever had:

☐ Headaches
☐ Loss of smell
☐ Dizziness
☐ Pins & needles in arms or legs
☐ Numbness in fingers or toes
☐ Neck pain
☐ Neck stiffness
☐ Autoimmune Disorders
☐ Chronic Infections
☐ Back pain
☐ Menstrual Pain
☐ Menstrual Irregularity
☐ Mood Swings
☐ Depression
☐ Fainting
☐ Fatigue
☐ Sleeping problems
☐ Cold Hands or feet
☐ Heart/Circulatory Problems
☐ Loss of Balance
☐ Nervousness
☐ Ulcers
☐ Constipation
☐ Diarrhea
☐ Upset Stomach
☐ Heartburn
☐ Allergies/Asthma
☐ Irritability

LIST ANY MEDICATIONS YOU ARE TAKING:

____

____

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 mention below any health conditions or concerns you may have about your:

Children ____

Spouse ____

Mother ____

Father ____

Other ____

Have you ever been to a chiropractor before? Yes   No   How often? ________ Doctor's name? ______________________

Have you ever:

Bought bottled water: Yes   No

Belonged to a health club: Yes   No

Consumed vitamins or supplements: Yes   No

Have you ever been to a doctor who put you on a health development plan?   Yes   No   I don't know

If Yes, what was his/her name? ______________________________

How long were you on it? ___________________________________

What did it consist of? _____________________________________

What were the results? _____________________________________

Where they permanent? ____________________________________

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

______________________________   ____________________

Signature   Date