

Name: _____ Patient #: _____ Age: _____ Date: _____

Address: _____
Residence and mailing City State Zip Code

Home Telephone () _____ Work Phone () _____

Email Address _____ Male _____ Female _____

~~Social Security #~~ _____ ~~Driver's Lic #~~ _____ Birthdate _____

Occupation/Employer's Name and address _____

Single _____ Married _____ Divorced _____ Widowed _____ Spouse's Occupation/Employer _____

No. of children: _____ (In Canada) ~~Health Card #~~ _____ ~~Version Code~~ _____

Reason for consulting our office? _____

Who may we Thank for referring you to our office? _____

YOUR HEALTH PROFILE

WHY THIS FORM IS 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 health potential and wellness services in the future. 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.

THE BEGINNING YEARS (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.

YOUR CHILDHOOD YEARS

YES NO UNSURE

YES NO UNSURE

Did you have any childhood illnesses?

Did you have any serious falls as a child?

Did you play youth sports?

Did you take / use any drugs?

Did you have any surgery?

Have you fallen / jumped from a height over three feet? (i.e. crib, bunk bed, trees)

Were you involved in any car accidents as a child?

Was there any prolonged use of medicine such as antibiotics or an inhaler?

Did you suffer any other traumas (physical or emotional)

Were you vaccinated?

As a child, were you under regular Chiropractic care?

COMMENTS: _____

ADULT - (18 TO PRESENT)

YES NO

YES NO

Do / did you smoke?

Do / did you drink alcohol?

Have you been in any accidents?

Have you had any surgery?

Do / did you play any adult sports?

Do / did you participate in extreme 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 _____