

## YOUR HEALTH PROFILE

Date \_\_\_\_\_

### PERSONAL INFORMATION

Name \_\_\_\_\_ Sex M  F  Age \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone Res \_\_\_\_\_ Bus \_\_\_\_\_ Health Card # \_\_\_\_\_ Ver Code \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Do you have Ext. Health Care? Yes  No  Not sure

Marital Status M  S  W  D  CL  Spouse's Name \_\_\_\_\_ Parent's Name (if under 18) \_\_\_\_\_

No of Children \_\_\_\_\_ Names \_\_\_\_\_ Referred By: \_\_\_\_\_

Have you ever had previous chiropractic care? Y  N  When? \_\_\_\_\_ With Whom? \_\_\_\_\_

Medical Doctor \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Are there recent X-Rays available? Y  N  Where? \_\_\_\_\_

*The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This form will help uncover the layers of damage, primarily to your nervous system, which have resulted in less than optimum health.*

Following your Chiropractic examination, we will outline a course of care to allow your body to begin correcting these layers of damage so you can recover your natural innate health potential.

### ADDRESSING THE ISSUE THAT BROUGHT YOU TO OUR OFFICE:

If you have no symptoms or complaints, and are here for wellness services, please check here

If you are symptomatic, please complete the following:

- Where does it hurt? \_\_\_\_\_
- How long have you had this? \_\_\_\_\_
- Have you ever had this before? Y  N  If yes, when? \_\_\_\_\_
- Is the problem there - all the time  comes and goes  • Is the problem getting - worse  no change  better
- Does the pain travel anywhere? \_\_\_\_\_
- Please describe how the pain feels: \_\_\_\_\_
- Any pain at night? Y  N  Does the pain effect the quality of your sleep? Y  N
- Does coughing, sneezing or straining aggravate the pain? Y  N
- What makes it worse? \_\_\_\_\_ What makes it better? \_\_\_\_\_

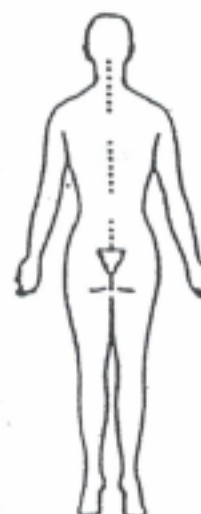
Please indicate the amount of pain/discomfort associated with your problem(s)



no pain |---|---|---|---|---|---|---|---|---|---| worst pain ever  
 0 1 2 3 4 5 6 7 8 9 10

Please use the symbols below to mark and describe each type of problem on the body diagrams.

- Sharp/stabbing pain XXXX
- Dull ache OOOO
- Numbness .....
- Stiff/tightness ////
- Tingling \*\*\*\*
- Burning +++++



**HAVE YOU EVER:**

Had an accident (car, fall, sports, other)? Y  N  Describe: \_\_\_\_\_

Had an operation? Y  N  Describe: \_\_\_\_\_

Had a fracture? Y  N  Describe: \_\_\_\_\_

Been hospitalized? Y  N  Describe: \_\_\_\_\_

**FAMILY HISTORY**

	Back Pain	Headaches	Arthritis	Cancer	Heart	Diabetes
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandparents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please describe other: \_\_\_\_\_

**ARE YOU TAKING ANY OF THE FOLLOWING?**

- Anti-inflammatories
- Sedatives
- Muscle relaxants
- Antibiotics
- Aspirin/Analgesics
- Birth control pills
- Insulin
- Antacids
- Vitamins/Herbs
- Other: \_\_\_\_\_

**LIFE STYLES:**

Smoking \_\_\_\_\_ packs/day      Alcohol \_\_\_\_\_ drinks/week      Coffee/tea/caffeinated beverage \_\_\_\_\_ cups/day

Exercise \_\_\_\_\_ times/week      Sleep \_\_\_\_\_ hours/day      on back  side  stomach

Your stress level can be described as:      minimal  moderate  severe  intolerable

PLEASE CHECK FOR ANY CONDITIONS PAST/PRESENT:

- Present**  
**Past**
- headaches
  - fever
  - fainting/dizziness
  - loss of sleep
  - loss of weight
  - convulsions
  - nervousness
  - poor concentration/memory
  
  - chest pain
  - high/low blood pressure
  - stroke
  - difficulty breathing
  - chronic cough
  
  - nausea
  - vomiting
  - heartburn
  - ulcer
  - belching or gas

- Present**  
**Past**
- neck pain/stiffness  
back pain
  - pain between shoulders
  - pain or numbness in arms,  
hands, legs, feet
  - bursitis
  - arthritis
  - swollen feet
  - spinal curvature
  
  - appetite changes
  - excessive thirst
  - constipation/diarrhea
  - jaundice
  - gall bladder trouble
  - colitis
  - hemorrhoids
  - black/bloody stools
  - changes in bowel or  
bladder habits
  - thyroid problems

- Present**  
**Past**
- blurred/fading vision
  - deafness
  - earaches
  - sore throat
  - hoarseness
  - difficulty swallowing
  - frequent colds
  - sinus infections
  - asthma
  - allergies
  - kidney infections/stones
  - problems with urination
  - blood in urine
  - bed wetting
  
  - infertility
  - sexual dysfunction
  
  - Women Only:**
  - excessive menstruation
  - irregular cycle
  - hot flashes
  - breast pain/lumps

CONDITIONS:

- osteoporosis
- fibromyalgia
- eczema/skin problems
- diabetes
- other (please specify)

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ARE YOU WEARING:

- heel lifts
- sole lifts
- inner soles
- arch supports
- orthotics

What do you hope to do better and enjoy more as a result of the improved health you will gain from Chiropractic care?

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Signature \_\_\_\_\_ Date \_\_\_\_\_

➔ please turn to back page to complete

*People go to a Chiropractor for a variety of reasons. Please indicate the type of care desired so that we may be guided by your wishes whenever possible.*

- Preventative care – I want my body to be brought to the highest state of health possible with Chiropractic care.*
- Corrective Care – I want to have the cause of the problem as well as the symptoms corrected and relieved.*
- Relief Care – I want symptomatic relief of this condition only.*
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*The Doctor of the future  
will give no medicine  
but will interest his patients  
in the care of the human frame,  
in diet, and in the cause and  
prevention of disease.*

*Thomas Edison*

