



Date: _____

WELLNESS HEALTH HISTORY PROFILE

In order to provide you the best possible wellness care, please complete this form.
All information is strictly **CONFIDENTIAL**.

Name: _____ DOB: _____ Age: _____

Male / Female: _____ Social Security #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home#: () _____ Work#: () _____ Cell#: () _____

Best time to contact: _____ How did you hear about the office? _____

Email address*: _____ Status: Single / Married / Divorced / Widowed

*Your email will not be shared with any third parties, and is used for occasional office announcements and promotions.

Spouses Name: _____ Spouses Employer: _____

of Children: _____

Occupation: _____ Employer Name/Address: _____

Emergency Contact: _____ Emergency Phone: _____

Reception Will Need To Make a Copy of Your Insurance Cards to Keep On File

Nature of Injury: AUTO WORK HOME

Date of Injury: _____ Date symptoms appeared: _____

Please describe: _____

Name of party responsible for payment: _____ Phone: _____

Do you have health insurance? NO YES Name of company: _____

If an auto accident, please provide: Insurance Company Name: _____

Contact Person: _____ Phone: _____ Claim #: _____

Name of the Insured: _____

I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient signature: _____ Date: _____



YOUR HEALTH PROFILE

What brings you into our office today?

Please briefly describe, including the impact it has had on your life.

Rate Severity (scale 1-10, 1 being mild) When and how did this start? Are symptoms constant or intermittent?

Since the problem started it is; ___the same ___getting better ___ getting worse

What makes the problem worse? _____

What, if anything, makes the problem feel better? _____

Does this interfere with your; ___Leisure ___Work ___Sleep ___Sports ___Other

Have you ever had same condition? NO YES If yes, when? _____

Have you seen other doctors for this condition? ___Chiropractor ___MD ___Other

Name/Address: _____ Date: _____

What was the diagnosis? _____

GENERAL HISTORY

Please list all medications you are taking, and why; (Prescription and non-prescription)

Have you had any surgeries and/or hospitalizations? NO YES

If yes, briefly explain: _____

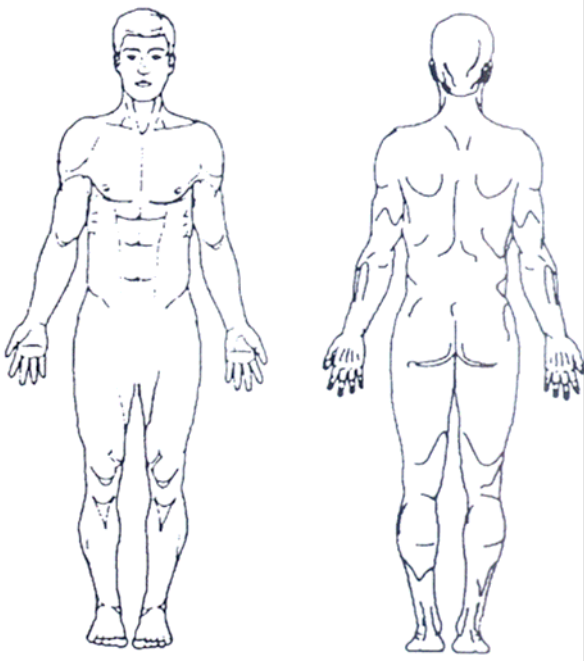
Have you ever had any work related injuries? NO YES

If yes, briefly explain: _____

Have you ever had any slips, falls or auto accidents? NO YES

If yes, briefly explain: _____

Please indicate where your complaint is on the following diagram:



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

- | | |
|------------------------|------------------------|
| Headaches | Buzzing in ears |
| Neck Pain | Stiff neck |
| Pins & needles in arms | Ringing in ears |
| Pins & needles in legs | Numbness in toes |
| Dizziness | Depression |
| Numbness in fingers | Constipation |
| Fatigue | Menstrual pain |
| Sleeping problems | Menstrual irregularity |
| Tension | Hot flashes |
| Ulcers | Cold hands |
| Irritability | Cold feet |
| Stomach upset | Diarrhea |
| Cold sweats | Loss of smell |
| Back pain | Loss of taste |
| Fever | Urinary problem |
| Mood Swings | Nausea |
| Eyes bothered by light | Fainting |

YOUR GOALS

On a scale of 1 to 10 (10 being extreme), describe your emotional/psychological/lifestyle stress levels:

Scale = ____ Occupational stress: _____

Scale = ____ Personal stress: _____

On a scale of 1 to 10 (10 being excellent), describe your habits and condition as it relates to:

Eating ____ Exercise ____ Sleep ____ General Health ____ Wellness lifestyle ____

Were concerned about your health & wellness goals, please take a moment to list your goals.

Wellness Goals		
Be Fit (Physical)	Eat Right (Nutritional)	Think Well (Psychological)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Thank you for filling out this form. It is your first step to Creating Wellness!

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

Signature: _____ Date: _____