

## General Information

Name \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home # (     ) \_\_\_\_\_ Work # (     ) \_\_\_\_\_ Ext. \_\_\_\_\_

Fax # (     ) \_\_\_\_\_ Beeper/Cellular # (     ) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

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

Employer's Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_     \_\_\_\_\_ Male     \_\_\_\_\_ Female     # of Kids \_\_\_\_\_

\_\_\_\_\_ Single     \_\_\_\_\_ Married     \_\_\_\_\_ Divorced     \_\_\_\_\_ Widowed     Name of Spouse \_\_\_\_\_

Names and ages of Kids \_\_\_\_\_

Main reason for consulting our office today? \_\_\_\_\_

\_\_\_\_\_ Referred by \_\_\_\_\_

**\*\*Please check if you are here for any of the following:**     \_\_\_\_\_ Car Accident     \_\_\_\_\_ Work Injury     \_\_\_\_\_ Other Injury

## Your Health Profile

**Why this form is important** - As a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a **lifetime** of health, happiness and vitality. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes not until it's too late! Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better assess your current status and more accurately determine what course of care will best help you reach your true health potential.

**The Beginning Years** - Many of the health challenges that people face later in life have their origins in stresses from the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

**Birth History** - Please check those items that apply to you

_____ Mother smoked/drank/drugs in pregnancy	_____ Epidural/Meds in labor	_____ Breech Vaginal Delivery
_____ Forceps Delivery	_____ Vacuum Extractor used	_____ Labor Induced
_____ C-Section Delivery	_____ Premature/Overdue	_____ Complications
_____ Very Short Labor	_____ Very Long Labor	
_____ Other _____		

(Over Please)

**Childhood Years (Age 0-17 yrs)** - Please check those items that apply to you

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Recurrent Childhood Illness | <input type="checkbox"/> Serious Falls                 | <input type="checkbox"/> Active in Sports        |
| <input type="checkbox"/> Car Accident(s)             | <input type="checkbox"/> Surgery/Stitches              | <input type="checkbox"/> Alcohol/Drug Abuse      |
| <input type="checkbox"/> Smoker                      | <input type="checkbox"/> Antibiotics/Other Medications | <input type="checkbox"/> Vaccinated              |
| <input type="checkbox"/> Broken Bones                | <input type="checkbox"/> Severe Emotional Stress       | <input type="checkbox"/> Under Chiropractic care |
| <input type="checkbox"/> Other _____                 |  |  |
- 

**Adult Years (Age 18 to present)** - Please check those items that apply to you

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Present Smoker   | <input type="checkbox"/> Former Smoker    | <input type="checkbox"/> OTC/Prescription Meds |
| <input type="checkbox"/> Alcohol Use  | <input type="checkbox"/> Surgery/Stitches | <input type="checkbox"/> Play Sports           |
| <input type="checkbox"/> Car Accident(s)  | <input type="checkbox"/> Work Injury      | <input type="checkbox"/> High Job Stress       |
| <input type="checkbox"/> High Personal Stress   | <input type="checkbox"/> Sit a lot        | <input type="checkbox"/> Drive a lot           |
| <input type="checkbox"/> Poor Sleep   | <input type="checkbox"/> Not Enough Sleep | <input type="checkbox"/> Poor/Inadequate Diet  |
| <input type="checkbox"/> No Exercise  | <input type="checkbox"/> Flat Feet        | <input type="checkbox"/> Wear Orthotics/Lifts  |
| <input type="checkbox"/> Severe Health Problems   | <input type="checkbox"/> Hard Falls       | <input type="checkbox"/> Broken Bones          |
| <input type="checkbox"/> Other Injuries _____   |   |  |
| <input type="checkbox"/> Have been under chiropractic care in the past - How long ago was your last adjustment? _____ |   |  |

### Clarifying Your Health Objectives

In addition to the main reason for your visit today, what additional health objectives do you have for your future?

\_\_\_\_\_  
\_\_\_\_\_

Have you ever been to another doctor who put you on a *Health Development Program*?     Yes    No    Not Sure

If yes: Doctor's Name \_\_\_\_\_  Medical Doctor    Chiropractor    Other

How long were you able to stay on the program? \_\_\_\_\_

What were your results? \_\_\_\_\_

Were the results permanent?    Yes    No    Somewhat

Are you as healthy (or healthier) today as you were 5 years ago?    Yes    No    Don't Know

If yes, what strategies have you used? \_\_\_\_\_

\_\_\_\_\_

Will you be as healthy (or healthier) as you are today, 5 years from now?    Yes    No    Don't Know

If yes, what strategies will you implement to get there? \_\_\_\_\_

\_\_\_\_\_

If no or don't know, what strategies could you implement to get there? \_\_\_\_\_

\_\_\_\_\_

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible.

Signed \_\_\_\_\_

Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_