Patient #:

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FUNCTIONAL HEALTH
COUNSELING • CHIROPRACTIC • NUTRITION

Full Name: _____Email Address: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Name of Spouse/Significant Other if applicable: _____ Number of Children & Age(s): _____

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

Home Phone #: _____ Work Phone #: _____Cell or Mobile Phone #: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip: _____ Emergency Name and Number: _____

How did you hear about Community Chiropractic? If someone referred you, what is their name? _____

Is there a specific reason for consulting our office, at this time? There is more room on the next page for additional writing.

_____

YOUR HEALTH PROFILE

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 the office, and second, to offer you the opportunity for improved health potential and wellness-services in the future. On a daily basis, we experience physical, chemical and emotional stress that can accumulate and result in a 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.

YOUR CHILDHOOD YEARS

Research shows 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	COMMENTS
Did you have any childhood illness?	☐	☐	☐	_____
Did you have any serious falls as a child?	☐	☐	☐	_____
Did you play youth sports?	☐	☐	☐	_____
Did you take/use any drugs?	☐	☐	☐	_____
Did you have any surgeries?	☐	☐	☐	_____
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?	☐	☐	☐	_____

YOUR ADULT YEARS

	YES	NO	UNSURE	COMMENTS
Do you sit at computer for long periods?	☐	☐	☐	_____
Do/did you smoke or drink alcohol?	☐	☐	☐	_____
Have you had any surgeries?	☐	☐	☐	_____
Have you been in a car/bike accident?	☐	☐	☐	_____
Do/did you participate in 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 THE OFFICE

If you have no specific symptoms or complaints, and you are here for Chiropractic Wellness Services please (X) here _____ and skip to the Family Profile section of this form. All others please briefly describe your chief area of complaint, including the effect it has had on your life.

_____

_____

If you are experiencing pain, is it… ☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

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

What makes it worse? _____

Yes, it interferes with… ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other Doctors seen for this problem (please list):

Chiropractors _____

Medical Doctors _____

Others _____

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

☐ Headache	☐ Pins and Needles in Leg	☐ Fainting	☐ Neck Pain
☐ Fatigue	☐ Loss of Smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Fever	☐ Ringing in Ears	☐ Nervousness
☐ Numbness in Fingers	☐ Numbness in Toes	☐ Loss of Taste	☐ Stomach Upset
☐ Pins and Needles in Arms	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping Problems	☐ Neck Stiff	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Buzzing in Ear	☐ Hot Flashes
☐ Cold Sweats	☐ Ulcers	☐ Problem Urinating	☐ Heartburn
☐ Menstrual Irritability	☐ Menstrual Pain	☐ Mood Swing	☐ Eyes Sensitive to Light

List any medications you are now taking: _____

FAMILY HEALTH PROFILE

We are not only interested in your health and well-being, but also about your family and loved ones. Please mention below any health conditions or concerns you may have about your…

Children _____

Spouse/Partner/Significant Other _____

Parents _____

Siblings_____

Others_____

Have you ever:

Bought bottled water: ☐ YES ☐ NO Belonged to a health club: ☐ YES ☐ NO Consumed vitamins or supplements: ☐ YES ☐ NO

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