Your Wellness History – Health Profile

Date: _______________**Name:** ___________________________________ **DOB:** ___________ **Age:** ______/ **Male Female**

Address: _______________________________________ **City:** ________________________ **State:** ____ **Zip:** ____________

Home # (   )___________________ **Work: (   )**____________________ **Cell: (   )**____________________________

Email address: ____ **Status: S M D W Spouse:**_________________

# of Children: ______ **Names/Age:** ____

Occupation: ____________________ **Employer:** ______________________________**Soc Sec #:**________________________

How were you referred to our office?____

Rate your health and wellness.

Place an 'X' that denotes where you believe is your current level of wellness.
Place an 'O' indicating where you would like your wellness to be.

YOUR HEALTH PROFILE

What brings you into our office today?____

Please briefly describe, including the impact it has had on your life. If you're only here for chiropractic wellness services please skip this part and go to the next page.

Rate Severity (scale 1-10, 1being mild) ________________________ **Is the pain: Sharp** _________ **Dull** __________

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**

Is it better or worse during certain times of day?____

Have you seen other doctors for this condition? ________________**Chiropractor** ____________________**MD**

Name/Address: ____ **Date:** _________________________

What was the diagnosis: ____

List all Medications you are taking:____

List Surgeries/Hospitalizations:____

Have you had any Work Injuries or Auto Accidents?____

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

q Headaches	q Buzzing in ears	q Irritability	q Diarrhea
q Pins & needles in arms	q Ringing in ears	q Cold hands	q Cold sweats
q Pins & needles in legs	q Numbness in toes	q Cold feet	q Mood Swings
q Dizziness	q Depression	q Fever	q Loss of smell
q Numbness in fingers	q Constipation	q Urinary problem	q Loss of taste
q Fatigue	q Menstrual pain/Irregular	q Fainting	q Back pain
q Sleeping problems	q Stroke	q Eyes bothered by light	q Neck Pain
q Tension	q Hot flashes	q Stomach upset	q Stiff neck
q Ulcers	qHeart Disease	qCancer	qBreathing Trouble
qArthritis	qAsthma	qLoss of Balance	qLoss of Memory

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Creating Wellness

YOUR GOALS

Ø On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/psychological/lifestyle stress levels:

Scale =____ Occupational stress: ____

Scale =____ Personal stress: ____

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

Eating________ Exercise________ Sleep________ General Health________ Wellness lifestyle____________

Do you Smoke?________ How much?____________ Do you drink alcohol?_______How much?______________

Were you taught proper body movement/care as a child?____

At our office we're concerned about your health and wellness goals. Please take a moment to list your goals

Wellness Goals

Be Fit. (*Physical*)	Eat Right. (*Nutritional*)	Think Well. (*Psychological*)
__________________	__________________	__________________
__________________	__________________	__________________
__________________	__________________	__________________

Please check all that are relevant.

Do you:	Would you like to know more about:
☐ Water - Drink ½ your body weight in ounces	☐ Proper Nutrition and meal planning
☐ Exercise regularly	☐ Proper exercise routines and techniques
☐ Take vitamins or supplements	☐ How to deal with LifeStyle stress

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 health and accident insurance policies are an arrangement between my insurance company and myself—not with this office. I authorize Chiropractic Life Center to release any medical information and to complete customary reports to assist me in collection from my insurance company. I understand that all fee's for services rendered are due at the time of service and cannot be deferred to a later date, as agreed upon in my financial policy contract.

Signature: ____ Date: __________________

Guardian' Signature:________________________________ Date: __________________

Please return this form to our staff and someone will be right with you.