Touch of Health Chiropractic:
A Creating Wellness
Center

Personal Information

NAME: _____ SSN #: _____ AGE: _____ DATE: _____
ADDRESS: _____
CITY / STATE / ZIP: _____
HOME PHONE #: _____ WORK PHONE#: _____ CELL#: _____
E-MAIL ADDRESS: _____ MALE ☐ FEMALE ☐
BIRTH DATE: _____ BEST TIME & NO. TO CONTACT: _____
OCCUPATION: _____ EMPLOYER'S NAME AND ADDRESS: _____
SINGLE: ☐ MARRIED: ☐ DIVORCED: ☐ WIDOWED: ☐
NO OF CHILDREN: _____ NAMES, AGES AND GENDER: _____
_____
_____
WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Your Health Profile

Why This Form Is Important

As a Creating Wellness Center, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your health potential.

Addressing what brought you to this office

If you have no symptoms or complaints and are here for **Chiropractic Wellness Services**, please skip to the "**General History**." (next page) Others, please briefly describe your chief concern, including the effect it has had on your life.

_____
_____

Health Concerns: List health concerns according to their severity	Rate of Severity 1= mild 10= worst imaginable	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	Are symptoms constant or Intermittent
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

If you are experiencing pain, is it… ☐ Sharp ☐ Dull Ache

Does the pain travel/radiate anywhere: ☐ No ☐ Yes – please describe

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

What makes it worse? _____

What have you done for this condition that has helped you feel better? _____
_____

What have you done for this condition that was of no help? _____
_____

☐ I do ☐ do not have a family history of this or similar symptoms (If you do, please explain)

_____
_____

Is this condition interfering with your: ☐ Work ☐ Leisure ☐ Sleep ☐ Sports/exercise/walking, ☐ Positive mental attitude ☐ Hobbies ☐ Other _____

Have you had to, or felt the need to make any "positive" changes in your life due to your condition? (i.e., eat better, less alcohol or drugs, meditate, less destructive sports, activities, etc.) if so what?

_____

_____

Other Doctors seen for this condition: ☐ Chiropractor ☐ Medical Dr. ☐ Other

1. Name/Address:_____

Date: _____ What was the diagnosis? _____

What was done? _____

2. Name/Address:_____

Date: _____ What was the diagnosis? _____

What was done? _____

General History:

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

☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐Neck pain
☐ Pins and needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of balance
☐ Dizziness	☐Buzzing in ears	☐Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Urinary Problem	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

List any medications you are taking and why: (prescription and non-prescription)

_____

_____

Have you had any surgery? (Please include all surgery)

1. Type _____ Date _____ Doctor _____
2. Type _____ Date _____ Doctor _____
3. Type _____ Date _____ Doctor _____

Accidents and/or injuries: auto, work related, or other (especially those related to your present problems).

1. Type _____ Date _____ Hospitalized ☐ Yes ☐ No
2. Type _____ Date _____ Hospitalized ☐ Yes ☐ No
3. Type _____ Date _____ Hospitalized ☐ Yes ☐ No

Have you ever had x-rays taken? (if yes) When _____ Where _____
Area of body: _____

Do you wear orthotics or heel lifts? ☐ Yes ☐ No

Please list your top three current stresses in each category:
1. Physical stress (falls, accidents, work postures, etc.)
a. _____
b. _____
c. _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, etc.)
a. _____
b. _____
c. _____

3. Psychological stress (work, relationships, finances, self-esteem, etc.)
a. _____
b. _____
c. _____

The Beginning Years

Research is showing that many of the health challenges that occur later in life originated during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Birth to 17 years of age

Unsure

	YES	NO	UNSURE
Did you have any serious childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take /use any drugs (prescribed or not)?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Were you involved in any car accidents?	☐	☐	☐
Was there prolonged use of medicine such as	☐	☐	☐
Antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas?	☐	☐	☐
(physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
Were you under regular Chiropractic care?	☐	☐	☐

COMMENTS: _____
_____

Adult-(18 to present)

	YES	NO
Do/did you smoke?	☐	☐
Do/did you drink alcohol (more than socially)?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐
Do you play any adult sports?	☐	☐
Do/did you participate in extreme sports?	☐	☐

On a scale of 1-10 describe your psychological/emotional stress levels: (1= none/ 10=extreme)
Occupational: _____
Personal: _____

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:
Eating habits: ____ Exercise habits: ____ Sleep: ____ General Health: ____ Mind-set: ____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please list below their names and any health conditions or concerns they may have:

Children: _____
Spouse: _____
Mother: _____
Father: _____
Brothers: _____
Sisters: _____
Others: _____

Have you ever:

Bought bottled water:	☐ Yes	☐ No
Belonged to a health club:	☐ Yes	☐ No
Consumed vitamins or supplements	☐ Yes	☐ No
If there is a need for dietary changes or nutrients would you like to be informed?	☐ Yes	☐ No
If there is a need for specific exercises would you like to be informed?	☐ Yes	☐ No
If there is a need for support in the psychological/mind/body/stress dimension of health would you like to be informed?	☐ Yes	☐ No

What Do You Know About Chiropractic?

In your own words, what do chiropractors do? _____
_____

Do you know what spinal nerve stress/subluxation is? ☐ Yes ☐ No

If yes, please describe _____
_____
_____

Do any friends or relatives see chiropractors? ☐ Yes ☐ No

If yes, so they use chiropractors for ☐ health maintenance/optimization ☐ health problems ☐ both

Are you seeking chiropractic care for ☐ health maintenance/optimization ☐ health problems ☐ both

What would you like to gain from chiropractic care? _____
_____
_____

Are there any other health concerns or anything else you'd like us to know about you? ☐ Yes ☐ No
If yes, please tell us. _____
_____
_____
_____

FEMALE ONLY: Is there a chance that you might be pregnant? ☐ Yes ☐ No

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

Signature_____ Date: _____

Thank you for filling out this form. It is your first step to **Creating Wellness!**
Return this to one of our team members and someone will be right with you.