Chiropractic Wellness Centers

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CONFIDENTIAL PATIENT INFORMATION *10-9-18*

Full name:		**Date:**	
Address: Street	City	State	Zip
Cell phone:	**Home phone:**	**Work phone:**	
Date of Birth:	**Email address:**		
Height:	**Weight:**	**Age:**	**Pregnant?** Yes ☐ No ☐
Occupation:			
Marital status: M S W D	**Significant Other/ Guardian name & Occupation:**		
Names of Children & Ages:			
Hobbies, Interests, Activities:			
Most Important Current Goal:			
Do you have insurance that covers Chiropractic care? Yes ☐ No ☐			
Who may we thank for referring you?			

What Brought You in to This Office: _____

*If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to **"General Health History"**.*

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present	Is your pain sharp or dull?	Does It Radiate? Where?
1.							
2.							
3.							
4.							
5.							

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

Is this condition interfering with any of the following:

Work ☐ Sleep ☐ Daily routine ☐ Sports/exercise ☐

*Other (please explain): _____

Family history of this or similar symptoms ☐ No ☐ Yes (Please explain): _____

What have you done for this condition? Was it of benefit?

a.

b.

c.

Which activities aggravate your condition? (Please explain):

a.

b.

c.

Other doctors you have seen for this condition:	When did you see them? (date, duration)
☐ "Limited Scope" Chiropractor (focuses mainly on neck and back pain)	
☐ "Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	
☐ Medical Doctor	
Other (please describe):	

What did they say was wrong?	
Did it help?	What did they do?

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

General Health History

Often times, the *accumulation of life's stress can lead to health problems and influence our ability to heal.*
Please pay close attention to this as it will help us help you!

Any surgery? (Please include all surgery)

1. Type:	When?	Where?
2.		
3.		

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

1. Type:	When?	Where?
2.		
3.		

Area of the body that X-rays , CT or MRI taken?

1.Type:	When?	Where?
2.		
3.		

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

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months any why: (prescription and non-prescription)

Medication	Reason:
1.	
2.	
3.	
4.	
5.	

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

1.	
2.	
3.	
4.	
5.	

(Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes ☐ No ☐ Maybe ☐
If dietary changes are indicated would you be willing to make changes in your diet?	Yes ☐ No ☐ Maybe ☐
Would you take whole food supplements if indicated?	Yes ☐ No ☐ Maybe ☐
If specific exercises or stretching would help would you consider adding them to your program?	Yes ☐ No ☐ Maybe ☐
If reducing stress would help you would you like to know ways to reduce stress?	Yes ☐ No ☐ Maybe ☐

Past Health History

Please mark the following conditions you have now (+) or have had (-):

☐ Upper Back Pain/ Tension	☐ Neck Pain/ Tension	☐ Shoulder Pain/ Tension	☐ Arm Pain/ Numbness	☐ Hand Numbness/ Weakness	☐ Carpal Tunnel
☐ Mid Back Pain/ Tension	☐ Lower Back Pain/ Tension	☐ Leg Pain/ Numbness	☐ Headaches/ Migraines	☐ Insomnia/ Sleep Problems	☐ Arthritis
☐ Allergy	☐Sinus Problems	☐ Asthma	☐ Arteriosclerosis	☐ Heart Disease	☐ High Blood Pressure
☐ Low Blood Sugar	☐ Bladder Trouble	☐ Weight Trouble	☐ Constipation	☐Diarrhea	☐ Gas/Bloating
☐ Irritability	☐ Fatigue	☐ HIV (Aids)	☐ Anemia	☐ Cancer	☐ Gall Bladder Problems
☐ Gout	☐ Irregular Periods	☐ Menstrual Problems	☐ Stroke	☐ Thyroid Problems	☐ Ringing in ears
☐ Cold Sores	☐ Depression	☐ Diabetes	☐ Ulcers	☐ Nervousness	☐ Dizziness

Other (please explain) _____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. **Physical stress** (falls, Sports, accidents, work postures, etc.)
   a.
   b.
   c.

2. **Chemical stress** (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a.
   b.
   c.

3. **Mental /emotional stress** (work, relationships, finances, self-esteem, etc.)
   a.
   b.
   c.

On a scale of 1-10 (1 being very poor and 10 being excellent) please grade your present levels of stress:

Including physical, chemical and mental / emotional stress:

At work:	At home:	At play:

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:

How do you grade your physical health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you grade your emotional/mental health?

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

Is there anything else, which may help to better understand you, that has not been discussed?

Why are you here at this **point in time**?

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.

Patient Name: Date:

Signature: