CONFIDENTIAL HEALTH PROFILE

PERSONAL INFORMATION: *Please answer all questions*

Name _____Sex _____Date_____
Street Address _____
City_____ State_____ Zip_____
Home Phone (____)-____-_____ Work (____)-_____-_____ Cell (____)-____-_____
Occupation_____ Employer _____
Social Security_____-_____-_____ Date of Birth_____/_____/_____
Spouse _____E-mail_____ Referred by_____

PERSONAL HEALTH PROFILE:

****PLEASE READ:** This information is critical for us to understand your specific needs and deliver the appropriate care. Our lives are filled with physical, nutritional, and emotional stress. This stress is cumulative and over time wears us down. This results in a variety of symptoms and other health problems. Most often, this accumulation is gradual and unperceivable to us. Answering the following questions will allow us to better understand your health challenges and concerns.

☐ If you are not here for a specific pain or complaint and just want wellness chiropractic care please check this box.

Please list any health concerns you have, starting with why you are here today.	Have you had this problem before? What was the treatment/response?

We all have 3 sources of stress in our life: Nutritional, Physical and Emotional

Please list your Nutritional Stressors:

List your Medications		List your Vitamins		Allergies/Sensitivities	

Please list your top three Physical Stressors:

Exercise (Type and Frequency)	Hobbies	Job/Career

Please list your Emotional Stressors:

Type of Stress (Feelings)	Source of Stress (Problems)

How long has it been since you really felt good? _____
Are you healthier today than you were 5 years ago? _____
Are you planning on being healthier in 5 years from today? _____

- If yes, what do you plan on doing to reach that goal? _____
- If no, why not? _____

On a scale of 1-10, 10 being the best please rate the following habits:
Sleep _____ Exercise _____ Eating _____ General Health _____ Mindset _____

Do you smoke tobacco? _____ *If yes how much?* _____
Do you drink alcohol? _____ *If yes how much?* _____
Do you consume caffeine? _____ *If yes how much?* _____

Are you specifically here as a result of an auto accident? _____
When was the last auto accident you were involved with? _____
Please briefly describe the event. Include where you were seated, location of impact, speed of both vehicles, and if you had a seatbelt on._____
_____
_____
_____

Are there any hospitalizations, illnesses, surgeries or traumas that you have **recently** experienced that we should talk about? _____

FAMILY HEALTH PROFILE:

As an office, we are not only concerned with your health and wellbeing, but also the health and wellbeing of your family. Please note for us any health conditions or concerns you have for your:

Spouse: _____
Children: _____
Mother: _____
Father: _____
Siblings: _____
Other: _____