

Health 4 Life

Name: _____ Date: _____

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

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

THE BEGINNING YEARS (TO AGE 17)

Research is showing 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.

YOUR CHILDHOOD YEARS

Yes No Unsure

Yes No Unsure

Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was there any prolonged use of Medicine such as antibiotics or on inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you suffer any other traumas (physical or emotional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you take / use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	As a child, were you under regular Chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Have you fallen / jumped from a height over three feet? (i.e. crib, bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

COMMENTS: _____

ADULT - (18 TO PRESENT)

Yes No

Yes No

Do / did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Do / did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>
Do / did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Do / did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	On a scale of 1 –10 describe your stress level: (1 = none / 10 = Extreme)		
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	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** symptoms or complaints, and are here for wellness services skip to **“Health Profile.”**
Others need to briefly describe the 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: Sleep Work Hobbies Sitting Walking Leisure

Health Profile:

Other Doctors seen for this problem (Please list)

_____ Chiropractor
_____ Medical Doctor
Other _____

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

Skin/Hair <input type="checkbox"/>	Bone/Joint <input type="checkbox"/>	Fainting <input type="checkbox"/>	<input type="checkbox"/> Neck pain
Nose/Throat <input type="checkbox"/>	Fatigue <input type="checkbox"/>	Back Pain <input type="checkbox"/>	Loss of Balance <input type="checkbox"/>
Eyes <input type="checkbox"/>	Nervousness <input type="checkbox"/>	<input type="checkbox"/> Headaches	Pins and Needles in arms <input type="checkbox"/>
Ears <input type="checkbox"/>	Numbness in toes <input type="checkbox"/>	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Ulcers
Lungs/Breathing <input type="checkbox"/>	Depression <input type="checkbox"/>	<input type="checkbox"/> Irritability	<input type="checkbox"/> Tension
Heart <input type="checkbox"/>	Neck stiff <input type="checkbox"/>	<input type="checkbox"/> Cold Hands	<input type="checkbox"/> Cold Feet
Digestion <input type="checkbox"/>	Constipation <input type="checkbox"/>	<input type="checkbox"/> Fever	<input type="checkbox"/> Hot Flashes
Genital <input type="checkbox"/>	Lights bother eyes <input type="checkbox"/>	<input type="checkbox"/> Heartburn	Dizziness <input type="checkbox"/>
Kidney/Bladder <input type="checkbox"/>	Pins and needles in legs <input type="checkbox"/>	Numbness in fingers <input type="checkbox"/>	Cold Sweats <input type="checkbox"/>
Liver/Gall Bladder <input type="checkbox"/>	Sleeping problems <input type="checkbox"/>	Diarrhea <input type="checkbox"/>	<input type="checkbox"/> Menstrual Irregularity
Loss of smell <input type="checkbox"/>	Mood swings <input type="checkbox"/>	Hormone <input type="checkbox"/>	Menstrual Pain <input type="checkbox"/>

List any medications you are taking _____

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 mention below any health conditions or concerns you may have about your:

Children _____
Spouse _____
Mother _____
Father _____
Siblings _____
Others _____

Please check all that apply

Feel better quickly Have a healthier body by keeping my nerve system healthy
Have a healthier spine Live a healthier lifestyle

Would you like to receive our Upcoming Office Events and Newsletter via e-mail or mail

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