Chiropractic • Physical Therapy • Nutrition

Name ______ Age ______ Date ______

Health Concerns

What are your major health problems/concern, (even if you do not consider them related to chiropractic care they give us an insight into what is going on with your nervous system and brain)? If you have none and are coming to us for wellness care, please list some of your primary concerns.

Date of Onset ______ Using the lines below please give brief Description

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______

What are the goals you hope to achieve as a result o working with us?

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______

Past Health History

Operation/Hospitalizations: ☐ None

Year ______ Reason ______

Procedure ______ Lingering Effects ______

Automobile Accident ☐ None

Year ______ Reason ______

Procedure ______ Lingering Effects ______

Injuries/Illnesses ☐ None

Year ______ Reason ______

Procedure ______ Lingering Effects ______

Fracture/Dislocations ☐ None

Year ______ Reason ______

Procedure ______ Lingering Effects ______

Have you had any of the following in the last twelve Months Please check one or more ☐ None

☐ Lab Work Date ______ Where? ______

☐ X-Rays Date ______ Where? ______

☐ MRI's Date ______ Where? ______

Name ______ Date ______

Symptom checklist. Please circle all symptoms

Eyes
- ☐ Watery Eyes
- ☐ Itchy Eyes
- ☐ Swollen Eyelids
- ☐ Blurred Vision
- ☐ Dark Circles

Skin
- ☐ Acne
- ☐ Hives, rashes
- ☐ Hair Loss
- ☐ Flushing/Hot flashes
- ☐ Excessive Sweating

Mind
- ☐ Poor Memory
- ☐ Confusion
- ☐ Poor Concentration
- ☐ Stuttering/Stammering
- ☐ Learning Disabilites

Energy
- ☐ Fatigue
- ☐ Sluggishness
- ☐ Apathy
- ☐ Hyperactivity
- ☐ Restlessness

Ears
- ☐ Itchy Ears
- ☐ Ear Aches
- ☐ Ear Infections
- ☐ Drainage from Ears
- ☐ Ringing in Ears

Heart
- ☐ Irregular Heartbeat
- ☐ Rapid Heartbeat
- ☐ Chest Pains
- ☐ Frequent Illness
- ☐ Urgent Urination

Emotions
- ☐ Mood Swings
- ☐ Anxiety, Fear
- ☐ Irritability, Anger
- ☐ Depression
- ☐ Aggressiveness
- ☐ Nervousness

Joint/Muscles
- ☐ Feeling of Weakness
- ☐ Pain in Joints
- ☐ Arthritis
- ☐ Stiffness
- ☐ Limited Movement
- ☐ Aches in Muscles

Nose
- ☐ Stuffy Nose
- ☐ Sinus Problems
- ☐ Hey Fever
- ☐ Sneezing Attacks
- ☐ Excessive Mucous

Lungs
- ☐ Chest Congestion
- ☐ Asthma, Bronchitis
- ☐ Shortness of Breath
- ☐ Difficult Breathing

Head
- ☐ Headaches
- ☐ Faintness
- ☐ Dizziness
- ☐ Insomnia
- ☐ Migranes

Women
- ☐ Menopause
- ☐ Low Libido
- ☐ Freq Yeast Infection
- ☐ UTI's
- ☐ PMS

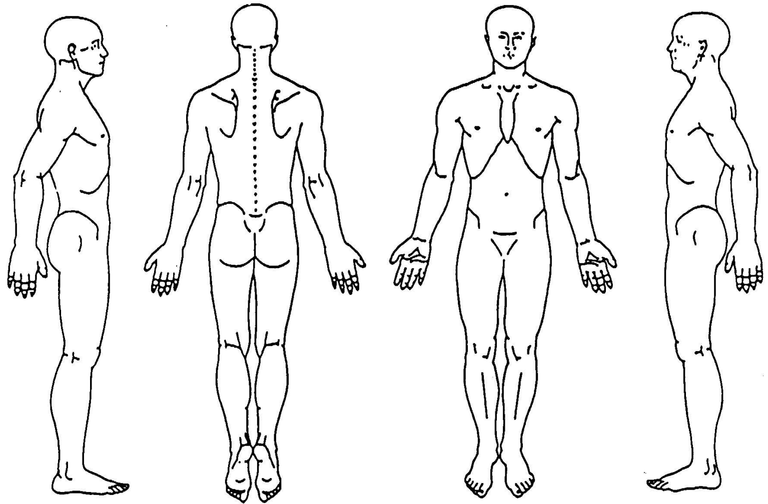
Mouth/Throat
- ☐ Chronic coughing
- ☐ Dry Mouth
- ☐ Often Dear Throat
- ☐ Sore Throat
- ☐ Swollen Tongue/Lips
- ☐ Cranker Sores

GI Tract
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating
- ☐ Belching
- ☐ Passing Gas
- ☐ Stomach Pains

Weight
- ☐ Binge Eating
- ☐ Cravings
- ☐ Excessive Weight
- ☐ Underweight
- ☐ Water Retention

Men
- ☐ Erectile Dysfunction
- ☐ Low Libido

Please indicate the location of your problems on the figures below.



List any other sypmtoms you are having?

List your symptoms in order of severity.

Is your condition a result of a work or automobile injury? ◯ Yes ◯ No

If your condition involves pain, please characterize type:

☐ Ache ☐ Sharp ☐ Constant ☐ Intermittent

Please Rate the amount of pain you are generally experiencing from the drop down box below.

Pain Rate

Have you had previous chiropractic care? ◯ Yes ◯ No If Yes, did you find if Effective?

Name

Address

Did you undergo any Treatments? ◯ Yes ◯ No If yes, please list the name of the Treatment.

Please list any prescription or non Prescriptions drugs you are taking

Please list any vitamins or herbs you are taking

Do you Smoke? ◯ Yes ◯ No If Yes, How long/much?

Alcohol? If Yes, How long/much?

Diet

Caffeine? ◯ Yes ◯ No If Yes how much per day? ____ per week? ____

What Kind? ____ Other ____

	per day?	per week?
How Many servings of bread do you eat		
How Many servings of fast food do you eat		
How Many servings of Sugary Snacks do you eat		
How Many servings of vegetables do you eat		
How Many servings of fruit do you eat		
How Many servings of meat do you eat		

How Many times a day do you have a bowel movement? ____

Family Health History

Please review the conditions listed below. Indicate those that are current health problems of a family member by writing the Letter "C" under his/her column. Use a letter "P" to indicate a past problem. Space that do not apply should be left blank.

Conditions	**Father Age ____**	**Mother Age ____**	**Spouse Age ____**	**Brother(s) Ages ____**	**Sister(s) Ages____**	**Children Ages ____**
Alcoholism/Addiction						
Alzheimer's Disease						
Allergies/Hay Fever						
Arthritis						
Cancer (Indicate)						
Depression						
Diabetes						
Digestive Problems						
Heart Disease						
High Blood Pressure						
Insomnia						
Kidney Problems						

Liver Disease						
Mental Health Problems						
Migraines						
Osteoporosis						

If any of the above family members are deceased, please list their age at death and cause:

Please List any other major conditions that run in your family:

Sleep Evaluation: (Please mark Yes or No)Text

Do you have trouble getting to Sleep?

Do you have trouble staying asleep, awaking every few hours?

Do you feel fatigued or groggy when you get up in the morning?

Is it hard to wake up and get going in the morning?

Do you snore loudly?

Are you substantially overweight?

Has anyone witnessed you sleeping, and noticed that you regularly stop breathing for several seconds?

Do you wake up with a sore throat or headache very often?

Do your arms or legs make abrupt, jerky movements when you're in bed? (This is called Periodic Limb Movement Disorder)

Do you have uncomfortable, tingly, achy or creepy-crawly feeling in your legs when you lie down (This is called Restless Leg Syndrome)

For Women: Are you awaked by night sweats, or from being to hot?

Micellaneous

Do you have any mercury fillings in your Teeth?

Do you get cold hands or feet on a regular basis?

Do You bruise easily?

Financial Policy

Payment is due at time of services.   We accept cash, Visa, or Mastercard

Authorization

I authorize release of information/records to my physicians, lawyers, employers, and/or insurance companies. I authorize the performance of diagnostic and therapeutic procedures.

____ ____________________

Patient/Guardian Signature　　　　　　　　Date