Your Health Profile

First Name_____ **Last Name**_____ **MI**_____ **Nickname** _____ **M F**

Home Address_____ **City**_____ **State**_____ **Zip** _____

Home Phone_____ **Mobile Phone**_____

Email_____
By providing my email address, I authorize my doctor to contact me via the email address(es) provided.

SSN_____ **DOB** _____ **Age**_____ **Employ. Status:** Employed FT Student PT Student Other Retired Self Employed

Occupation _____ **Employer**_____ **Work Phone** _____

Marital Status: Single Married Divorced Separated Widowed **No. of Children** _____ **Ages**_____

Race *(circle one)* White Black/African American Hispanic American Indian/Alaskan Native Other_____
I choose not to specify

Multi-Racial *(circle one)* Yes No Unknown **Ethnicity** *(circle one)* Hispanic or Latino Not Hispanic or Latino I choose not to specify

Who will be responsible for your bill? Self Spouse Parent-Guardian Other Insured's

Insured's Name_____ **Insured's SSN** _____ **Insured's DOB** _____

Insured's Employer _____ **Work Phone** _____ **Insurance Phone**_____

Insurance Company _____ **ID #**_____ **Group #**_____

Is your visit due to an accident? No Yes ***(if yes, please see receptionist for an injury report and instructions for insurance information.)***

Emergency Contact_____ **Relationship**_____ **Phone**_____

Whom shall we thank for referring you to our clinic? _____

Do/did you smoke? **Yes** **No, Never** **Former Smoker**

If yes, how often do you smoke: *(circle one)* *current every day smoker* *current sometimes smoker*

If yes, what is your level of interest in quitting smoking? *(0 – no interest to 10 very interested)* _____

Do/did you drink alcohol? **Yes** **No** **Have you ever been in any car accidents?** **Yes** **No**

Have you had any work-related injuries? **Yes** **No** *If yes, please describe* _____

Have you had any surgeries? **Yes** **No** *If yes, please list* _____

Do/did you play any adult sports? **Yes** **No** **Do/did you participate in extreme sports?** **Yes** **No**

Have you had any falls or traumas? **Yes** **No** **Have you had dental or eye problems?** **Yes** **No**

Do you exercise regularly? **Yes** **No** **What position/s do you sleep in?** **Stomach** **Side** **Back**

On a scale of 1 – 10 (10 = highest), describe your stress level: **Occupational Stress**_____ **Personal Stress**_____

How would you describe your diet? *(Circle One)* ***Poor*** ***Below Average*** ***Average*** ***Above Average*** ***Excellent***

Would you like more information on healthy eating habits or a weight management program? *(Circle One)* ***Yes*** ***No***

Your Chief Complaint

- ❖ Briefly describe the complaint that brought you to the clinic, including the effect it has had on your life:

  _____

  _____

- ❖ On a Pain Scale of 1 - 10 (10 = highest), what is your pain level: *(Circle One)* 1 2 3 4 5 6 7 8 9 10
- ➢ When did your symptoms start? _____
- ➢ How did your symptoms begin? _____
- ❖ How often do you experience your symptom? *(Circle One)* ***Constantly(76-100%) Frequently(51-75%) Occasionally(26-50%) Intermittently(0-25%)***
- ❖ If you are experiencing pain, is it… *(Circle One)* ***Sharp Dull ache Numb Shooting Burning Tingling Comes and Goes Travels Constant***
- ❖ Since the complaint began, it is… *(Circle One)* ***About the Same Getting Better Getting Worse***
- ❖ What makes the complaint get worse _____
- ❖ My complaint interferes with *(Circle all that Apply)* ***Work Sleep Walking Sitting Hobbies Leisure Family***

  How often does it interfere? All of the time Most of the time Some of the time A little of the time None of the time
- ❖ Please list other Doctors seen for this complaint or any other health condition: ***Chiropractor*** _____

  Medical Doctor _____ ***Other*** _____ Date of last physical exam _____
- ❖ Has any doctor diagnosed you with Hypertension (high blood pressure) presently? ***Yes No If yes, describe:***

  _____
- ❖ Has any doctor diagnosed you with Diabetes presently? ***Yes No If yes, what kind? Type I Type II***
- ❖ Have you had an X-ray or CT scan or MRI of your low back spine in the past 28 days? ***Yes No***
- ❖ Are you pregnant? Yes No

Health Problems *Please check all symptoms you have currently been suffering from, even if they do not seem related to your current complaint.*

- ❑ High Blood Pressure
- ❑ Diabetes
- ❑ Cancer
- ❑ Low Back Pain
- ❑ Tingling in Legs
- ❑ Numbness in Toes
- ❑ Diarrhea/Constipation
- ❑ Problems Urinating
- ❑ Pregnancy Problems
- ❑ Menstrual Pain
- ❑ Irreg. Menstruation

- ❑ Neck Pain
- ❑ Hyper/hypothyroid
- ❑ Tingling in Arms
- ❑ Numbness in Fingers
- ❑ Headaches
- ❑ Dizziness
- ❑ Jaw Pain
- ❑ Ringing in Ears
- ❑ Light Sensitive Eyes
- ❑ Sinus Trouble
- ❑ Ear Aches

- ❑ Loss of Balance
- ❑ Middle Back Pain
- ❑ Tension
- ❑ Asthma
- ❑ Shortness of Breath
- ❑ Chest Pains
- ❑ Muscle Cramps
- ❑ Arthritis
- ❑ Fatigue
- ❑ Depression
- ❑ Anxiety/Nervous

- ❑ Multiple Sclerosis
- ❑ Epilepsy
- ❑ High Cholesterol
- ❑ Upset Stomach
- ❑ Cold Hands/Feet
- ❑ Cold Sweats
- ❑ Night Sweats
- ❑ Hot Flashes
- ❑ Irritability
- ❑ Mood Swings
- ❑ Heartburn/Ulcers

Please list any other health problems _____

Medication Information

Current medications, including dosage and frequency if known. If there are no current medications, check here: _____

	Dosage	Frequency	Start date		Dosage	Frequency	Start date
1.				5.			
2.				6.			
3.				7.			

List any known allergies you have had to any medications. If no allergies are known, check here: _____

1. _____ 3. _____
2. _____ 4. _____

The statements made above are accurate to the best of my recollection and knowledge and I agree to allow this office to examine me for further evaluation and treatment.

Signed _____ ***Date*** _____