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	❑ Neck Pain	❑ Loss of Balance	❑ Multiple Sclerosis
❑ Diabetes	❑ Hyper/hypothyroid	❑ Middle Back Pain	❑ Epilepsy
❑ Cancer	❑ Tingling in Arms	❑ Tension	❑ High Cholesterol
❑ Low Back Pain	❑ Numbness in Fingers	❑ Asthma	❑ Upset Stomach
❑ Tingling in Legs	❑ Headaches	❑ Shortness of Breath	❑ Cold Hands/Feet
❑ Numbness in Toes	❑ Dizziness	❑ Chest Pains	❑ Cold Sweats
❑ Diarrhea/Constipation	❑ Jaw Pain	❑ Muscle Cramps	❑ Night Sweats
❑ Problems Urinating	❑ Ringing in Ears	❑ Arthritis	❑ Hot Flashes
❑ Pregnancy Problems	❑ Light Sensitive Eyes	❑ Fatigue	❑ Irritability
❑ Menstrual Pain	❑ Sinus Trouble	❑ Depression	❑ Mood Swings
❑ Irreg. Menstruation	❑ Ear Aches	❑ Anxiety/Nervous	❑ 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* ______________