



# Your Wellness History - Health Profile

Date: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  Male  Female  
 Name: \_\_\_\_\_ What do you prefer to be called? \_\_\_\_\_  
 Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home #: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_  
 Best time to contact: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Status:  Single  Married  Partnered  Divorced  Widowed  
 # of Children \_\_\_\_\_ Name of Spouse \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employer Name/Address: \_\_\_\_\_  
 Whom may we thank for referring you to our office? \_\_\_\_\_

**Rate your health and wellness.**

Place an 'X' that denotes where you believe is your current level of wellness.  
 Place an 'O' indicating where you would like your wellness to be.

0 - 50 Very Challenged	50 - 75 Challenged	75 - 100 Transitional	100 - 125 Good	125 + Excellent
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## YOUR HEALTH PROFILE

> What brings you into our office today?

Please briefly describe, including the impact it has had on your life. If you're only here for chiropractic wellness services please skip this part and go to "General History" on the next page.

Rate Severity (scale 1-10, 1 being mild) When and how did this start? Are symptoms constant or intermittent?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

> Since the problem started it is: \_\_\_\_\_ the same \_\_\_\_\_ getting better \_\_\_\_\_ getting worse

What makes the problem worse? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

> What, if anything, makes the problem feel better? \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

> Does this interfere with your: \_\_\_\_\_ Leisure \_\_\_\_\_ Work \_\_\_\_\_ Sleep \_\_\_\_\_ Sports \_\_\_\_\_ Other

> Have you see other doctors for this condition? \_\_\_\_\_ Chiropractor \_\_\_\_\_ MD \_\_\_\_\_ Other

Name / Address: \_\_\_\_\_ Date: \_\_\_\_\_

What was the diagnosis: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_





# Your Wellness History - Health Profile, page 2

## GENERAL HISTORY

> Please list all medications you are taking, and why; (Prescription and non-prescription)

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> Have you had any surgeries and/or hospitalizations? \_\_\_ Yes \_\_\_ No

If yes, briefly explain \_\_\_\_\_

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> Have you ever had any work related injuries? \_\_\_ Yes \_\_\_ No

If yes, briefly explain \_\_\_\_\_

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> Have you ever had any slips, falls or auto accidents? \_\_\_ Yes \_\_\_ No

If yes, briefly explain \_\_\_\_\_

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Please check all symptoms (now or in the past) you have ever had, even if they do not seem related to your current problem.

Current Past

- Headaches
- Pins & needles in arms
- Pins & needles in legs
- Dizziness
- Numbness in fingers
- Fatigue
- Sleeping problems
- Tension
- Ulcers
- Buzzing in ears
- Ringing in ears
- Numbness in toes
- Depression
- Constipation
- Menstrual pain
- Menstrual irregularity
- Pregnant

Current Past

- Irritability
- Cold hands
- Cold feet
- Fever
- Urinary problems
- Fainting
- Eyes bothered by light
- Stomach upset
- Diarrhea
- Cold Sweats
- Mood swings
- Loss of smell
- Loss of taste
- Back pain
- Neck pain
- Stiff neck
- Kidney problems

Current Past

- Asthma
- Sinus/Allergies
- Chest pain
- Heart Attack/Stroke
- Alcohol/Drug abuse
- High/Low Blood Pressure
- Seizures
- Shingles
- Diabetes
- Psychiatric problems
- Hemorrhoids
- Cancer/Chemotherapy
- Anemia
- Arthritis
- Shoulder pain
- Leg/Hip pain





# Your Wellness History - Health Profile, page 3

## YOUR GOALS

> On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/psychological/lifestyle stress levels:

Scale = \_\_\_\_ Occupational stress: \_\_\_\_\_

Scale = \_\_\_\_ Personal stress: \_\_\_\_\_

> On a scale of 1 to 10 (1 = poor, 10 = excellent), describe your habits and condition as it relates to:

Eating \_\_\_\_\_ Exercise \_\_\_\_\_ Sleep \_\_\_\_\_ General Health \_\_\_\_\_ Wellness lifestyle \_\_\_\_\_

Please check all that are relevant:

Do you:

- Water - Drink ½ your body weight in ounces
- Exercise regularly
- Take vitamins or supplements

Would you like to know more about:

- Proper Nutrition and meal planning
- Proper exercise routines and techniques
- How to deal with LifeStyle stress

Thank you for filling out this form.  
It is your first step to Creating Wellness!

I consent to a professional and complete chiropractic examination, and to any radiographic examination that the doctor deems necessary. I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Do you have any insurance you would like us to check for you? \_\_\_\_\_

Insurance Name \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Insured's Name \_\_\_\_\_ DOB \_\_\_\_\_

Member/ID # \_\_\_\_\_

Your Relation To The Insured \_\_\_\_\_

Please return this form to our staff and someone will be right with you.

