



# HEALTH PROFILE

Today's Date:    /    /

ID# : \_\_\_\_\_

## PATIENT DEMOGRAPHICS

Name: \_\_\_\_\_ Birth Date:    /    /    Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Marital Status:  Single  Married    Do you have Insurance  Yes  No    Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Relation to Emergency Contact: \_\_\_\_\_

Name of Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Permission to share medical information with emergency contact:  Yes  No

Number of Children: \_\_\_\_\_ Names, Ages and Gender: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## LIST YOUR HEALTH CONCERNS BELOW

**Primary** \_\_\_\_\_ When did it start? \_\_\_\_\_ **Second** \_\_\_\_\_ When did it start? \_\_\_\_\_

**Third** \_\_\_\_\_ When did it start? \_\_\_\_\_ **Forth** \_\_\_\_\_ When did it start? \_\_\_\_\_

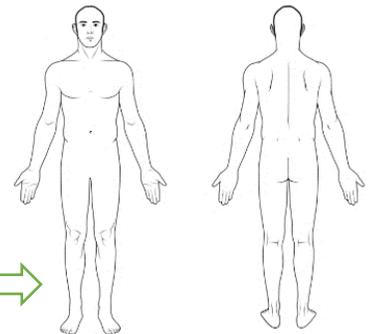
On a scale of 1-10 with 10 being the worst pain and zero being no pain, rate your above complaints by circling the number.

Primary or Chief complaint is:    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**

Second complaint is:    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**

Third complaint is:    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**

Forth complaint is:    **1**    **2**    **3**    **4**    **5**    **6**    **7**    **8**    **9**    **10**



**PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms

**R= Radiating**    **B= Burning**    **D= Dull**    **A= Aching**    **N= Numbness**    **S= Sharp/Stabbing**    **T= Tingling**

When is the problem at its worst?  AM  PM  MID-DAY  LATE PM

How long does it last?  It is constant     It is on and off during the day     It comes and goes throughout the week.

How did the health concern start?  Suddenly     Gradually     Unknown     Post-Injury

If started with an injury explain: \_\_\_\_\_

Condition(s) ever been treated by anyone in the past?  NO  YES If yes, when: \_\_\_\_\_ by who: \_\_\_\_\_

What relieves your symptoms: \_\_\_\_\_

What makes symptoms worse: \_\_\_\_\_

Is your balance or walking ability affected?  NO  YES

What do you think is causing your problem? \_\_\_\_\_



**CHIROPRACTIC HISTORY**

Have you ever seen a Chiropractor before?  YES  NO Last visit: \_\_\_\_\_ Name: \_\_\_\_\_

What is their specialty?  Pain Relief  Physical Therapy & Rehab  Nutritional  Subluxation-based  Other: \_\_\_\_\_

What would you like to gain from chiropractic care?  Resolve existing condition(s)  Overall Wellness  BOTH

**Please CHECK PAST problems and CIRCLE CURRENT problems**

Headache	Infertility	Dizziness	Prostate Problems	Ulcers
Neck pain	Frequent Colds/Flu	Loss of Balance	Impotence/Sexual Dysfunction	Heartburn/Gastric Reflux
Jaw Pain/TMJ	Convulsions/Epilepsy	Fainting	Digestive Problems/IBS	Heart Problem
Shoulder Pain	Tremors/Tics	Double Vision	Colon Trouble	High Blood Pressure
Upper Back Pain	Chest Pain	Blurred Vision	Diarrhea/Constipation	Low Blood Pressure
Mid Back Pain	Pain w/Cough or Sneeze	ringing in Ears	Menopausal Problems	High Cholesterol
Low Back Pain	Sinus/Drainage Problems	Depression	PMS	Liver Trouble
Hip Pain	Difficulty Breathing	Hearing Loss	Menstrual Problem	Hepatitis (A,B,C)
Sciatica	Lung Problems	Irritable	Bed Wetting	Kidney Trouble
Scoliosis	Ear Infections	Mood Changes	Learning Disability	Gall Bladder Trouble
Spinal Stenosis	Allergies	Eating Disorder	ADD/ADHD	Brain Fog
Degenerative Disc	Lupus	Trouble Sleeping	Chronic Fatigue	Thyroid Problems
Fibromyalgia	Tiredness	Anxiety	Poor Circulation	Cold Hands/Feet
Throbbing Pain	Dead Feeling	Pins/Needles Pain	Heavy Feeling	Skin Problems
Cramping	Swelling	Electric Shocks	Poor Wound Healing	Hot Sensation
Pain/Numb/Tingling in Arms/Hands/Fingers	Pain/Numb/Tingling in Legs/Feet/Toes	Foot or Knee Problems	Swollen/Painful Joints	Excessive Thirst or Urination
OTHER: _____				

If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the **PAST**, **C** for **CURRENTLY** have or **N** for **NEVER** have had:

Broken Bone  Dislocations  Tumors  Cancer  Rheumatoid Arthritis  Osteoarthritis  
 Scoliosis  Heart Attack/Heart Disease  Stroke  Diabetes I or II  Seizures  Spinal Surgery  
 Joint Replacement  Foot Surgery  Herniated Disk  Bulging Disk  Pacemaker/Defibrillator  
 Implanted Cord/Bladder Stimulator  Plantar Fasciitis  Morton Neuroma  Pinched Nerve  
 Other Serious Conditions/ Surgeries: \_\_\_\_\_



**FAMILY HISTORY**

Does anyone in your family suffer from the same condition(s) you do?  Yes  No If yes, whom?

Grandmother  Grandfather  Mother  Father  Sister  Brother  Daughter  Son

Which condition(s): \_\_\_\_\_

Have they ever been treated for their condition?  Yes  No  Unsure

Any other hereditary conditions the doctor should be aware of that run in your family?  Yes  No

If yes, please explain: \_\_\_\_\_

**TRAUMAS: Physical Injury History**

Notable childhood injuries?  Yes  No **If yes, please explain:** \_\_\_\_\_

Youth or college sports?  Yes  No **If yes, list major injuries:** \_\_\_\_\_

Have you ever had any significant falls, surgeries, or other injuries?  Yes  No

If you were in a RECENT accident, what type of accident was it?  Personal Injury  Motor Vehicle Accident  Work Injury

Please explain: \_\_\_\_\_

Exercise Frequency?  None  1-2x/week  3-5x/week  Daily

How do you normally sleep?  Back  Side  Stomach

Do you wake up:  Refreshed and ready  Stiff and tired  Other: \_\_\_\_\_

Average hours you spend sleeping at a time?  <1 hour  1-2 hrs  2-3hrs  3-4hrs  4-5hrs  5-6hrs  6+hrs

Do you commute to work?  Yes  No **If yes, how many minutes per day?** \_\_\_\_\_

List any problems with flexibility (ex. Putting on shoes/socks, etc.) \_\_\_\_\_

**How many combined HOURS / DAY do you typically spend sitting at a desk, on a computer, tablet or phone?** \_\_\_\_\_

**TOXINS: Chemical & Environmental Exposure**

If you consume any of the following, please indicate how often (select ALL that apply for each item below):

	Last 48 Hrs	Daily	Weekends	Occasionally	Never		Last 48 Hrs	Daily	Weekends	Occasionally	Never
Alcohol						Caffeine					
Sugar						Cigarettes					
Artificial Sweeteners						Cigars					
Sugary Drinks						Pipe Tobacco					
Dairy						Recreational Drugs					
Processed Foods											

**THOUGHTS: Emotional Stresses & Challenges**

Please rate your STRESS level for each:

	NONE		MODERATE		HIGH			NONE		MODERATE		HIGH	
Home	0	1	2	3	4	5	Money	0	1	2	3	4	5
Work	0	1	2	3	4	5	Health	0	1	2	3	4	5
Life	0	1	2	3	4	5	Family	0	1	2	3	4	5



Please list any medication(s) / Vitamins / Herbs / other that you are taking: \*If necessary, please list on a separate sheet of paper.

	MEDICATION   SUPPLEMENT:	DOSAGE:	FREQUENCY TAKEN:	PURPOSE FOR TAKING:
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Please list ALL allergies/sensitivities to medication, food, and other items.

Item you react to:	Reaction:
_____	_____
_____	_____

**ACTIVITIES OF LIFE**

Please identify how your current condition(s) affects your ability to do routine activities (SELECT WHAT APPLIES)

Carry Children/Groceries	Painful (can do)	Painful (limits)	Unable to Perform
Sit to Stand	Painful (can do)	Painful (limits)	Unable to Perform
Climb Stairs	Painful (can do)	Painful (limits)	Unable to Perform
Pet Care	Painful (can do)	Painful (limits)	Unable to Perform
Extended Computer Use	Painful (can do)	Painful (limits)	Unable to Perform
Read/Concentrate	Painful (can do)	Painful (limits)	Unable to Perform
Getting Dressed	Painful (can do)	Painful (limits)	Unable to Perform
Shaving	Painful (can do)	Painful (limits)	Unable to Perform
Sexual Activities	Painful (can do)	Painful (limits)	Unable to Perform
Sleep	Painful (can do)	Painful (limits)	Unable to Perform
Static Sitting	Painful (can do)	Painful (limits)	Unable to Perform
Static Standing	Painful (can do)	Painful (limits)	Unable to Perform
Yard Work	Painful (can do)	Painful (limits)	Unable to Perform
Walking	Painful (can do)	Painful (limits)	Unable to Perform
Washing/Bathing	Painful (can do)	Painful (limits)	Unable to Perform
Sweeping/Vacuuuming	Painful (can do)	Painful (limits)	Unable to Perform
Dishes	Painful (can do)	Painful (limits)	Unable to Perform
Laundry	Painful (can do)	Painful (limits)	Unable to Perform
Garbage	Painful (can do)	Painful (limits)	Unable to Perform
Driving	Painful (can do)	Painful (limits)	Unable to Perform
Other:	Painful (can do)	Painful (limits)	Unable to Perform

Please circle the number that best describes the question asked.

- How would you rate your pain RIGHT NOW?  
 0    1    2    3    4    5    6    7    8    9    10
- What is your typical or AVERAGE pain?  
 0    1    2    3    4    5    6    7    8    9    10
- What is your pain level at its WORST? (How close to 10 does your pain get at its worst?)  
 0    1    2    3    4    5    6    7    8    9    10



