Health Profile

Today's Date: ___/___/ ____

First Name: _____ **Last Name**: _____ **Date of Birth**: ___/___/___

Street Address: _____

City: _____ **State**: _____ **Zip**: _____ **Email**: _____

Mobile Phone: _____ **Home Phone**: _____

Occupation: _____ **Number of Years**: _____

Marital Status: ❒ Married ❒ Divorced ❒ Widowed ❒ Single **Name of Spouse**: _____

How did you discover us (who referred you)? _____

Part I: Your Health Concern or Symptoms

1. What are your major complaints? *Please indicate what brings you to our office.*

_____

_____

_____

2. When and how did this/these complaint(s) begin? *Approximate dates are acceptable.*

_____

_____

3. Please *circle* the level to which this health concern affects these aspects of your functioning/quality of life:

Work	0	1	2	3
Social Life	0	1	2	3
Exercise	0	1	2	3
Recreation/Play	0	1	2	3
Walking	0	1	2	3

Eating	0	1	2	3
Rest/Sleep	0	1	2	3
Sitting	0	1	2	3
Love Life	0	1	2	3
Concern About Health	0	1	2	3

0 – Does not affect me 1 – Slightly affects me 2 –Moderately affects me 3 – Drastically affects me

Part II: Medical History

1. Select all **medical conditions** you have experienced at *present* or in the *past (circle all that apply)*:

•Ankle Pain •Arm Pain •Arthritis •Asthma •Back Pain •Broken Bones •Cancer •Chest Pain •Depression •Diabetes •Dizziness •Elbow Pain •Epilepsy •Eye/Vision Problems •Fainting •Fatigue •Foot Pain •Genetic •Spinal Condition •Hand Pain •Headaches •Hearing Problems •Hepatitis •High Blood Pressure •Hip Pain •HIV •Jaw Pain •Joint Stiffness •Knee Pain •Leg Pain •Menstrual Problems •Mid-Back Pain •Minor Heart Problem •Multiple Sclerosis •Neck Pain •Neurological Problems •Pacemaker •Parkinson's •Polio •Prostate Problems •Shoulder Pain •Significant Weight Change •Spinal Cord Injury •Sprain/Strain •Stroke •Heart Attack

•Other: _____

_____

2. Select any **allergies** *(circle all that apply)*:

•Animals •Aspirin •Bees •Chocolate •Dairy •Dust •Eggs •Gluten •Latex •Molds •Penicillin •Pollen •Rubber •Seasonal Allergies •Shellfish •Soaps •Other: _____

TURN OVER PAGE TO COMPLETE

3. Please list any **serious bodily injuries** and **approximate date** of injury. *Include broken bones, sprains, concussions, accidents, and areas that have not healed properly:*

4. List any **surgeries** (circle all that apply and include year surgery was performed):

•Back •Brain •Elbow •Foot •Hip •Knee •Neck •Neurological •Organ •Shoulder •Wrist

•Other:

5. Has your spine ever been professionally cared for by a Doctor of Chiropractic (D.C.)? ❒Yes ❒No

➢ By whom and when? Number of Years Under Care:

➢ Were x-rays taken? ❒Yes ❒No Date of last chiropractic visit:

6. Select the **types of medications** you are currently taking (circle all that apply):

•Allergy •Anxiety •Birth Control •Cardiovascular •Diabetes •Insulin •Muscle Relaxers •Pain Killers •Seizure

•Other:

Part III: Personal Habits

1. Which **hand** is dominant? ❒Left ❒Right ❒ Ambidextrous
2. If you carry a **bag** or purse regularly, which shoulder? ❒Left ❒Right
3. **Sleeping** position? ❒Back (face up) ❒ Stomach ❒Left side down ❒Right side down ❒In twisted positions
4. Do you use tobacco/**nicotine**-containing products? ❒Yes ❒No Years of use:
5. Do you drink **alcohol**? ❒Yes ❒No How many drinks per day?
6. Do you drink **caffeine**? ❒Yes ❒No How many cups per day? Did you drink caffeine today? ❒Yes ❒No
7. Do you **exercise** at least 3 days per week for 30+ minutes at a time? ❒Yes ❒No
   - ➢ If yes, what form(s) of exercise?
8. How much **water** do you drink *daily*?
   a) ❒ 0-12 fluid ounces (1 water bottle)
   b) ❒ 12-24 fluid ounces (2 water bottles)
   c) ❒ 24-64 fluid ounces (up to half gallon)
   d) ❒ 64-128 fluid ounces (up to 1 gallon)
9. Would you say you are under **stress**? (*circle one)* •None •Some •Much
   - ➢ Please explain:
10. When stressed, how do you "**center yourself**" or "regroup"? _____

11. Is there some aspect of your life that pleases you, brings you joy, or helps you to feel better about yourself?

Part IV: How do you hope to benefit from care in this office?

For <u>each</u> of the lines to the right, please list one choice:

A = "very important to me"
B = "somewhat important to me"
C = "not so important to me"
D = "does not apply"

____ Improvement of physical symptoms
____ Improvement of emotional/mental symptoms
____ Improve my ability to respond to stress
____ Improvement in enjoyment of life
____ Overall improved quality of life

PLEASE MAKE SURE YOU HAVE SIGNED THE "INFORMED CONSENT" AND "PRIVACY" FORMS
IF FILLING OUT THE FORM ONLINE, PLEASE EMAIL TO info@healingwavechiro.com