

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) c) 24-64 fluid ounces (up to half gallon)
b) 12-24 fluid ounces (2 water bottles) 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 each of the lines to the right, please list one choice:

A = “very important to me”	_____ Improvement of physical symptoms
B = “somewhat important to me”	_____ Improvement of emotional/mental symptoms
C = “not so important to me”	_____ Improve my ability to respond to stress
D = “does not apply”	_____ 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**