

Name: _____ Patient #: _____ Age: _____ Date: _____
 Address: _____
Residence and mailing City State Zip Code
 Home Telephone () _____ Work Phone () _____
 Email Address _____ Male _____ Female _____
 Social Security # _____ Driver's Lic.# _____ Birthdate _____
 Occupation/Employer's Name and address _____
 Single _____ Married _____ Divorced _____ Widowed _____ Spouse's Occupation/Employer _____
 No. of children: _____ (In Canada) Health Card# _____ Version Code: _____
 Reason for consulting our office? _____
 Who may we Thank for referring you to our office? _____

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

THE BEGINNING YEARS (TO AGE 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

YOUR CHILDHOOD YEARS

	YES	NO	UNSURE		YES	NO	UNSURE
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you suffer any other traumas (physical or emotional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you take / use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	As a child, were you under regular Chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Have you fallen / jumped from a height over three feet? (i.e. crib, bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

COMMENTS: _____

ADULT - (18 TO PRESENT)

	YES	NO		YES	NO
Do / did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Do / did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>
Do / did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Do / did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	On a scale of 1 - 10 describe your stress level: (1 = none / 10 = Extreme)		
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Occupational _____		
			Personal _____		

On a scale of Poor, Good, Excellent describe your:
 Diet _____ Exercise _____ Sleep _____ General Health _____