

Name: _____ Social Security #: _____ Date: _____

Date of Birth: _____ Male Female Single Married Widowed # of Children _____

Address: _____ City: _____ State: _____ Zip _____

Phone #: Home: _____ Work: _____ Other: _____ Email: _____

Your Health Profile

Your Current Lifestyle:

The single most critical factor in your health potential is your current lifestyle. The things you do regularly, both positively and negatively, and your willingness to change the negative habits have more influence on your future health than any other factor.

I am here for: Wellness A Presenting Complaint _____ Both

Your Present Health Status:

I consider my general health: Excellent Good Fair Poor

I Currently Exercise _____ Times/_____ Days/week, Including: Aerobic Strength Building Stretching

About Your Diet: Vegetarian Veg. Plus Fish Veg., Fish & Poultry Omnivore Vegan

Do you eat dairy? Yes No Commercial Hormone Free Only Unsure

Weight Problem? Yes No Do You Smoke? Yes No _____ Years Quit _____ Years ago

Do you play adult sports? Yes No List: _____ Extreme sports? Yes No List: _____

Stress Level: (Scale: 0-10/ 0=None, 10=Extreme) Occupation/career/school _____ Personal _____

What methods do you to decrease stress? _____

Have you ever had a doctor prescribe a Wellness or Health Promotion Plan for you? Yes No

Describe: _____

What benefits did you gain: _____

Have you ever been checked on a regular basis for Nervous System interference (Subluxation)?

Yes No By Whom? _____

Name of medical doctor (if applicable) _____ Alternative Provider(s)? _____

What supplements do you take regularly? _____

Medications? _____ None

Do you have a diagnosed medical condition? List: _____

How much sleep do you get per nite? _____ How much water do you drink per day? _____

Do you drink carbonated beverages? Diet Regular # of cans/week _____

Do you drink bottled or filtered water Yes No

Have you had organs surgically removed? Yes No Which ones? _____

Other Surgical Procedures? _____

Your Health History:

To help us better evaluate your health potential; knowing your history as completely as possible is necessary. Please answer all questions regardless of their relationship to the reason for your visit today.

Many health issues can be traced back to your developmental years. Please answer the following to the best of your ability.

About your early development (through age 16):

Did your mother take medications during pregnancy/delivery? Yes No _____

Was your mother under stress or was there trauma during pregnancy? _____

Were you born vaginally? Yes No Circle Applicable: Forceps Suction MD Midwife

Did you receive routine vaccinations? Yes No Limited _____

Were you ill a lot? (More than twice per year) Yes No During what time frame? _____

List Childhood health issues if applicable: _____

Were you in any accidents? Yes No _____

Did you suffer any traumas (mental/emotional or physical) Yes No

What sports did you participate in? When? _____

What medication did you take? _____

Were you under regular Chiropractic care? Yes No

Age 16 through Present:

Please check all applicable symptoms:

| Present | Past | Present | Past | Present | Past | Present | Past |
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