

Name: _____ Patient #: _____ Date: _____
 Age: _____ Male: _____ Female: _____ Single: _____ Married: _____ Divorced: _____ Widowed: _____
 # of Children: _____ Occupation: _____
 Reason for consulting 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 in the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Your Childhood Years (Circle Y/N/Unsure)

		Comments
1. Did you have any childhood illnesses?	Y N Unsure	_____
2. Did you have any serious falls as a child?	Y N Unsure	_____
3. Did you play youth sports?	Y N Unsure	_____
4. Did you take/use any drugs?	Y N Unsure	_____
5. Did you have any surgery?	Y N Unsure	_____
6. Have you fallen/jumped from a height greater than 3 feet? (ie criib, bunk bed, trees)	Y N Unsure	_____
7. Were you involved in any car accidents as a child?	Y N Unsure	_____
8. Was there any prolonged use of medicine such as antibiotics or inhalers?	Y N Unsure	_____
9. Did you suffer any traumas (physical or emotional)?	Y N Unsure	_____
10. Were you vaccinated?	Y N Unsure	_____
11. As a child, were you under regular chiropractic care?	Y N Unsure	_____

Adults (Circle Y/N/Unsure)

		Comments
1. Do / did you smoke?	Y N Unsure	_____
2. Do / Did you drink alcohol?	Y N Unsure	_____
3. Have you had any surgery?	Y N Unsure	_____
4. Do / did you smoke?	Y N Unsure	_____
5. Do / did you play any adult sports?	Y N Unsure	_____
6. Do / did you participate in any extreme sports?	Y N Unsure	_____

7. On a scale of 1-10, describe your stress level:

(1 = none; 10 = extreme)

Occupational: _____

Personal: _____

8. On a scale of poor, good, or excellent, describe your:

Diet: _____ Exercise: _____ Sleep: _____ General Health: _____