

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here ____ **“Wish to have Chiropractic Wellness Services”** and skip to **“Family Health Profile.”** Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

If you are experiencing pain, is it...

Sharp Dull Comes and goes Travels Constant

Since the problem started, it is... About the same Getting better Getting worse

What makes it worse: _____

Yes, it interferes with: Work Sleep Walking Sitting Hobbies Leisure

Other Doctors seen for this problem (please list)

- Chiropractor _____
 Medical Doctor _____
 Other _____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

- | | | | |
|---------------------------------------------------|---------------------------------------------------|-------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Pins and Needles in arms | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Neck stiff | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers |

List any medications you are taking _____

Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____
Spouse _____
Mother _____
Father _____
Brothers _____
Sisters _____
Others _____

Have you ever:

- Bought bottled water: YES NO
Belonged to a health club: YES NO
Consumed vitamins or supplements: YES NO

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Signature

Date

