

Name: _____ Patient #: _____ Age: _____ Date: _____
 Address: _____
Residence and mailing City State Zip/Postal Code
 Home Telephone () _____ Work Phone () _____ 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

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.

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?	0 D 0	Was there any prolonged use of medicine such as antibiotics or an inhaler?	0 0 0
Did you have any serious falls as a child?	0 0 0	Did you suffer any other traumas? (physical or emotional)	0 0 0
Did you play youth sports'?	0 D 0	Were you vaccinated?	0 0 0
Did you take/use any drugs?	0 D 0	As a child, were you under regular Chiropractic care?	0 0 0
Did you have any surgery?	0 0 0		
Have you fallen/jumped from a height over three feet'? (i.e. crib, bunk bed, tree)	0 0 0		
Were you involved in any car accidents as a child?	0 0 0		

COMMENTS: _____

ADULT - (18 TO PRESENT)	YES NO		YES NO
Do/did you smoke?	0 0	Do/did you play any adult sports?	0 0
Do/did you drink alcohol?	0 0	Do/did you participate in extreme sports'?	0 0
Have you been in any accidents?	0 0	On a scale of 1-10 describe your stress level: (1=none/10=Extreme)	
Have you had any surgery?	0 0	Occupational _____	
		Personal _____	

On a scale of Poor. Good or Excellent describe your:

Diet Exercise Sleep General Health