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
Did you have any childhood illnesses?	o	D	O
Did you have any serious falls as a child?	0	O	0
Did you play youth sports'?	O	D	O
Did you take/use any drugs?	O	D	O
Did you have any surgery?	O	O	O
Have you fallen/jumped from a height over three feet'? (i.e. crib, bunk bed, tree)	0	O	O
Were you involved in any car accidents as a child?	0	0	0

	YES	NO	UNSURE
Was there any prolonged use of medicine such as antibiotics or an inhaler?	O	0	0
Did you suffer any other traumas? (physical or emotional)	0	O	O
Were you vaccinated?	0	0	O
As a child, were you under regular Chiropractic care?	0	0	0

COMMENTS: _____

ADULT - (18 TO PRESENT)

	YES	NO
Do/did you smoke?	0	O
Do/did you drink alcohol?	0	0
Have you been in any accidents?	O	O
Have you had any surgery?	0	O

	YES	NO
Do/did you play any adult sports?	0	0
Do/did you participate in extreme sports'?	0	0

On a scale of 1-10 describe your stress level:
(1=none/10=Extreme)

_____ Occupational

_____ Personal

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

Diet Exercise Sleep General Health