

# Your Wellness Profile

Active Living Chiropractic  
Carpentersville, IL (847) 551-4410

<b>Personal Information</b>	Name: _____
	Address: _____
	City: _____ State: ____ Zip: _____
	Birth date: _____ Age: ____ Gender: M F
	SS #: _____ DL #: _____
	Home Phone #: (     ) _____ - _____
	Cell Phone #: (     ) _____ - _____
	E-Mail Address: _____
Referred By: _____	

Employer: _____
Work Phone #: (     ) _____ - _____
Marital Status: ____ Spouse's Name: _____
Spouse's Employer: _____
Spouse's Birth Date (if policy holder): _____
Children & Ages: _____ _____ _____
Best Time to Contact You: _____

*As a lifestyle and wellness based chiropractic center, we focus on your ability to be healthy. Our goals are first, to address your immediate concerns that brought you to our office, and second, to offer you the opportunity of improved health potential and wellness in the future. On a daily basis we adapt to physical, bio-chemical, and emotional stresses that can accumulate over time. Improper adaptation to these stresses may result in a serious loss of health and well-being. In most cases these effects are gradual and not even felt until they become serious. By answering the following questions you will give us a profile of the specific health challenges you have faced which allows us to better assess the challenges to your full health potential, and allows us the information needed to give you our best recommendations.*

## Immediate Concern:

**If you do not have a current complaint and are here for Chiropractic Wellness Services please check the box and skip to the next section, otherwise please continue:**

What current health challenges are you experiencing (Pain/Symptoms/Conditions)? \_\_\_\_\_

\_\_\_\_\_

Date Began: \_\_\_\_\_ Have you experienced this condition before? Y N If yes, when: \_\_\_\_\_

How often does this condition bother you? \_\_\_\_\_ Is the condition getting better or worse? \_\_\_\_\_

When is it at its worse? \_\_\_\_\_ Severity of complaint (Scale 0-10 / 10 being the worst): \_\_\_\_\_

Is the pain local or does it travel / radiate? \_\_\_\_\_ Is this condition work or auto accident related? Y N

Has this condition affected any of the following?  Sleep habits  Work  Leisure  Exercise Habits  Mental Attitude

Have you seen anyone else for this condition? \_\_\_\_\_ Were you helped? Y N

List all medications/supplements you are currently taking: (Prescription and Non-Prescription) \_\_\_\_\_

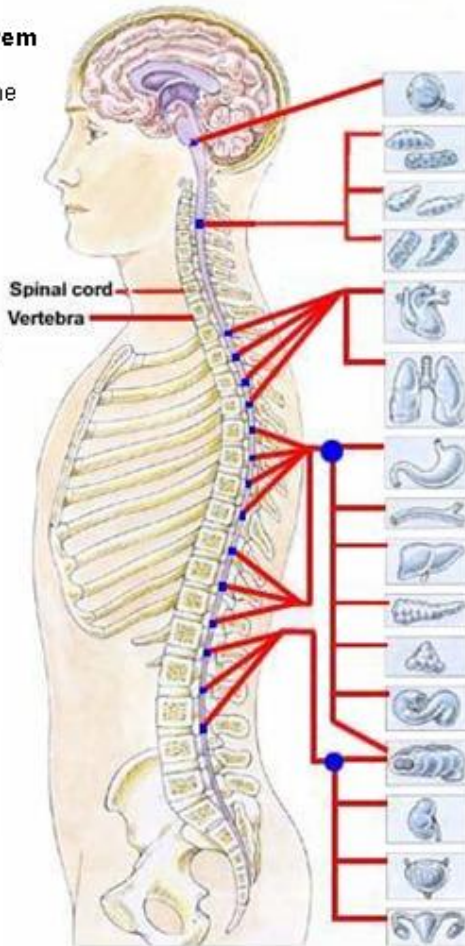
\_\_\_\_\_

## Personal Health History

Your nervous system controls and coordinates every function of your body. Symptoms may be a sign of neurological disturbance and/or dysfunction. Please specify accordingly by marking a **(C)** if you are currently or a **(P)** if you have previously experienced any of these symptoms so that we can properly evaluate the function of your nervous system.

### Motor & Sensory Nervous System

- Tension/Cervicogenic Headache
- Dizziness/Loss of Balance
- Jaw Pain/Clicking
- Neck Pain
- Arm/Hand Pain
- Arm/Hand Numbness/Tingling
- Mid Back Pain
- Scoliosis/Spinal Curvature
- Arthritis
- Stiff/Painful Joints
- Muscle Pain/Soreness
- Muscle Spasm/Trigger Points
- Low Back Pain
- Hip Pain
- Leg/Foot Pain
- Leg/Foot Numbness/Tingling
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_



### Autonomic Nervous System

- Vision changes
- Vertigo
- Sinus Congestion
- Frequent Colds
- Nervousness
- Heart Problems
- Lung Problems
- Heartburn
- Ulcers
- Liver Problems
- Diabetes
- Stress/Anxiety
- Digestion Problems
- Constipation
- Kidney Problems
- Prostate Problems
- Menstrual Pain
- Other: \_\_\_\_\_
- Fatigue
- Migraines
- Allergies
- Brain Fog
- Insomnia
- Chest Pain
- Asthma
- Indigestion
- Bloating
- Immune Deficiency
- Tiredness
- Depression
- Cramping
- Diarrhea
- Urinary Problems
- Sexual Dysfunction
- Infertility
- Other: \_\_\_\_\_

## Family History

	Heart Disease	Cancer	Diabetes	Arthritis	Other
<i>Father's Side</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<i>Mother's Side</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<i>Spouse</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
<i>Children</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

## Neurological Health and Spinal Maintenance History

Have you ever had Chiropractic care before? Y N Name of Doctor or Office: \_\_\_\_\_

Have you ever had spinal X-rays? Y N If yes, approximate date: \_\_\_\_\_ Do you wear orthotics or heal lifts? Y N

Have you ever had any surgery? Y N If yes, please explain \_\_\_\_\_

Have you had any recent accidents, work or sport injuries? Y N If yeas, please explain: \_\_\_\_\_

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## Current Health Habits

Please list your top stresses in each of the following categories:

*Physical Stress* (work, hobbies, posture, accidents, etc.): \_\_\_\_\_

*Biochemical Stress* (eating habits, smoke, work environment, medications, etc.): \_\_\_\_\_

*Psychological Stress* (work, relationships, self-esteem, finances, etc.): \_\_\_\_\_

Are you aware that stresses such as the ones above largely contribute to your current health condition/status? Y N

If yes, have you ever tried to improve upon those stresses affecting your current health status? Y N

## Personalization of Care

*Your satisfaction is our ultimate goal therefore we will do our best to customize your care to your personal preferences. There are many techniques and services offered in the chiropractic and healthcare fields, if you have had a previous experience (favorable or not) please indicate so along with any other preferences you may have so that we can provide the best service to you as possible.*

**Please check the box that is most appropriate for you:**

- I prefer traditional manual chiropractic adjustments (Manual joint manipulation i.e. popping and cracking)
- I prefer low force chiropractic techniques (Torque Release/Integrator Method, Drop table, Toggle, etc.)
- I would like the doctor to recommend the techniques best suited for my individual condition/concerns

**I am or may be interested in the following:**

- Therapeutic Massage
- Craniosacral Therapy
- Naturopathy (Nutritional therapy, homeopathy, herbal therapy, acupuncture/acupressure, etc.)
- Lifestyle/Health/Weight Loss Counseling or Coaching
- A Comprehensive Wellness Program (A complete program consisting of customized strength & cardiovascular exercise programs, nutritional supplementation & meal planning, personal development & stress reduction, personalized coaching, etc.)

***I attest that the statements made above are accurate and complete, and I agree to allow this office to proceed with further evaluation as deemed appropriate by the doctor:***

▶ **Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

***Thank you for filling out this form. It is your first step to Creating Wellness!  
Please return this form to our staff and someone will be right with you.***