Confidential **Patient** Profile

activeliving chiropractic

Name: _____

Address: _____

City:_____ State: ____ Zip: _____

Birth date:_____ Age: _____ Gender: M F

SS #:_____ DL #: _____

Home Phone #: ( ) _____-_____

Cell Phone #: ( ) _____-_____

E-Mail Address: _____

Referred By: _____

JOIN US ON FACEBOOK!

Employer: _____

Work Phone #: ( ) _____-_____

Marital Status: ____ Spouse's Name: _____

Spouse's Employer: _____

Spouse's Birth Date (if policy holder): _____

Children & Ages: _____

_____

_____

Health Insurance Carrier: _____

Member ID & Group #: _____

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) _____

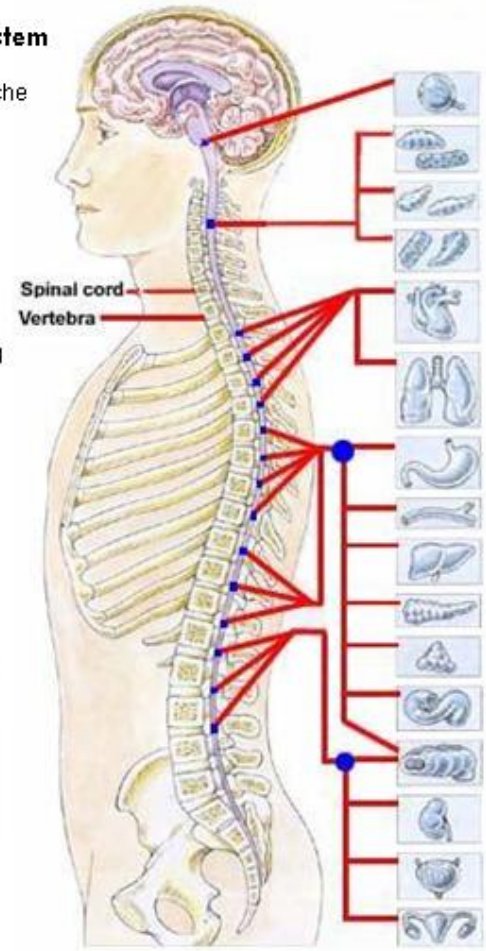
_____

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
Father's Side	☐	☐	☐	☐	☐ _____
Mother's Side	☐	☐	☐	☐	☐ _____
Spouse	☐	☐	☐	☐	☐ _____
Children	☐	☐	☐	☐	☐ _____

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 heel 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 yes, please explain: _____

_____

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. I understand that all fees (if any) are due at the time of service:

▶ **Patient Signature:** _____ **Date:** _____/_____/_____

Thank you for filling out this form. It is your first step towards Health & Wellness!
Please return this form to our front desk and someone will be right with you.

We would love to help you help others! Who do you know would be interested in a FREE Health Checkup?

1. NAME: _____ ***Phone Number:*** _____ ***Email:***_____

2. NAME: _____ ***Phone Number:*** _____ ***Email:***_____

3. NAME: _____ ***Phone Number:*** _____ ***Email:***_____