

PERSONAL HEALTH PROFILE

Patient's Name _____ Date _____ ABHC# _____

Address _____ Postal Code _____

Res. Phone _____ Bus. Phone _____ Cell. _____ Age _____

Birthdate _____ Height _____ Weight _____ # of children _____ email _____

Occupation _____ Employer _____ Name of Spouse _____
(or parent if minor)

Who referred you here or how did you learn of our office? _____

Spinal subluxations have a significant impact on your health and well-being. Please answer the following important questions to the best of your ability, in as much detail as is practical.

Your Childhood History

Describe all childhood impacts, especially hard falls, sports or car accidents, concussions, broken bones, etc.:

Please describe all significant or chronic childhood illnesses: _____

Were you given any prolonged doses of medications, such as antibiotics or inhalers? _____

Did you suffer any significant emotional traumas as a child? _____

As a child, did you receive regular chiropractic care? _____ Doctor's name? _____

Your Current History

Briefly describe your chief complaint, its location and the effect it has had on your life: _____

How long has this problem been present? _____ Have you ever had this problem in the past? _____

If so, when? _____ What do you think is *the cause* of your problem? _____

If you are experiencing pain, is it... _____sharp _____dull _____comes/goes _____travels _____constant

What makes the problem worse? _____ What makes it better? _____

What specific life activities does it interfere with (work, sleep, leisure etc.?) _____

Is your complaint related to a motor vehicle accident? ___y___n Is it related to a Worker's Comp. Injury? ___y___n

Other Doctors seen for this problem (please list)

Chiropractor _____ Medical Doctor _____ Other _____

On a scale of 1 - 10 describe your current stress level: (1=none / 10=extreme) Occupational _____ Personal _____

Please describe the following as either, poor, fair, good, or excellent:

Diet _____ Exercise _____ Sleep _____ Posture _____ General Health _____

Have you had x-rays of your spine within the last 2 years? _____ If so, where were they taken? _____

Most people have had literally dozens of impacts/stresses that can cause subluxations.

When was your most recent auto accident? _____ Front/side/rear-end collision? _____

Describe your most recent stress or strain while working _____

What sport or recreational activities do you do? _____

When was your most recent stress or strain during these activities? _____

Is there any other injury that you have had, minor or major, that we should know about? _____

Please put a **“C”** beside each symptom which you **currently** have (or experience on a recurring basis); please put a **“P”** beside each symptom you have had in the **past**.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Pins & 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"/> Ringing in ears | <input type="checkbox"/> Loss of hearing | <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"/> Stiff neck | <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"/> Light bothers eyes | <input type="checkbox"/> Problem urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Breathing difficulty | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Jaw problems | <input type="checkbox"/> Sinus problems |

List all drugs (medications) you are taking: _____

List any chronic disease(s) you may have: (arthritis, diabetes, cancer, heart disease, etc) _____

The statements made on this form are true to the best of my memory and I agree to allow this office to examine me for further evaluation:

Signature _____ Date _____

Doctor's Notes:
