A Place for Healing
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CONFIDENTIAL HEALTH PROFILE

Dear Patient: Please complete this questionnaire. Your answers will help us determine how best to serve you. THANK YOU.

Today's Date________________

Name (LAST / FIRST / MIDDLE) ________________________________ Age ________ Sex ________ Date of Birth ________________

Street Address ________________________ City ____________________ State ________ Zip Code ________________

Occupation _________________ Home Telephone ____________________ Cell Phone ________________________

Marital Status M S W D # of Children ______ Hobbies / Interests ________________________________

Referred By _______________________ E-mail Address ____

How did you hear about our office and Network Chiropractic? ____

YOUR HEALTH CONCERN OR SYMPTOM

What are your current health concerns?

1) Describe ______________________________ Date Began _________ Cause? __________________ Severity (1-10) ____

2) Describe ______________________________ Date Began _________ Cause? __________________ Severity (1-10) ____

3) Describe ______________________________ Date Began _________ Cause? __________________ Severity (1-10) ____

If more than 3 concerns, please list and describe on back of page

How have these concerns impacted your life? ____

What makes them better?________________________________ What makes them worse? __________________________

Have you done anything about these concerns or gotten any advice or treatment for it? ☐Yes ☐No If yes, when? ________

Who did you see?_________ What were you told? ______________________What was done? __________________

Have you ever received a spinal adjustment by a Chiropractor? ____________ By Whom? __________________________

How often did you receive adjustments? ___ For how long? _______ When did you receive your last adjustment?______________

If you stopped going, why? ____

Do you know what type of adjustments or what technique(s) or methods he or she used?_____________________________

Does your immediate family receive chiropractic adjustments?____

GENERAL PHYSICAL HISTORY

Have you ever injured your spine (neck, head, back, hips)? ☐Yes ☐No

Date of most significant injury:_________ Describe: ____

Date of most recent injury:____________ Describe: ____

Have you ever been in an Auto Accident? O Past Year O Past 5 Years O Over 5 Years O Never
Describe: ____

Have you had any other injuries (job, sports, etc.) ? O Past Year O Past 5 Years O Over 5 Years O Never
Describe: ____

Have you had any spinal x-rays, CAT scans or MRI's of your spine (head, neck, back or hips)? If yes, when? _________________

What were you told about them? ___________________________________ Where are these films now? ______________________

Have you had any surgeries? Describe: ____

Have you broken any bones or significantly sprained a part of your body? Describe: ___________________________________

Have you ever been hospitalized? O Past Year O Past 5 Years O Over 5 Years O Never

Describe: ____

Are you aware if your birth was: O Traumatic O Breech O "C" Section O Prolonged O Cord around Neck

Do you exercise regularly ____________ If yes, what kind? ____

MEDICATIONS, DIET AND CHEMICAL EXPOSURES

Please list all medications (prescription and non prescription) and the reasons you have taken them in the past 60 days: _________

____

Do you work with or around any chemicals, fumes, dust, powder, smoke, or any other toxic chemicals for prolonged periods?

If yes, explain ____

Do you have any allergies? Describe: ____

Are you on a special diet?______ If yes, what kind? ____

How would you describe your general daily eating habits? ____

Do you smoke? ☐Yes ☐No How often? ________
Do you drink alcohol? ☐Yes ☐No How often? ________
Do you use artificial sweeteners? (Nutrasweet, Equal, Aspartame) ☐Yes ☐No How often? _______

REVIEW OF SYSTEMS **Select all that apply and rate severity from (1-10) in space provided. Thank you**

Musculoskeletal
__Face/Jaw pain
__Neck pain
__Mid back Pain
__Low back pain
__Hip Pain
__Shoulder pain
__Elbow pain
__Wrist pain
__Knee pain
__Foot pain
__Joint pain or stiffness
__Weakness in muscles
__Muscle pain
__Back pain
__Cold extremities
__Difficulty Walking
__Radiating pain down arm
__Radiating pain down leg

Psychological
__Anxiety
__Difficulty sleeping
__Depression

Neurological
__Headache
__Dizziness
__Fainting
__Convulsions

Eyes
__Blurred vision
__Double vision

Ears, Nose, Mouth, Throat
__Hearing loss
__Ringing in the ears
__Difficulty chewing
__Difficultly swallowing
__Sinusitis

Cardiovascular
__Chest pain
__Palpitations
__History of heart attack

Respiratory
__Shortness of breath
__Productive cough
__Asthma
__TB

Constitutional
__Recent weight loss
__Recent weight gain
__Recent fever

Gastrointestinal
__Abdominal Pain
__Nausea
__Vomiting
__Constipation
__Diarrhea
__Bloody stools

Genitourinary
__Pain or difficulty urinating
__Blood in urine
__Inability to control urine

Genitourinary Male:
__Impotence
__Testicular pain
__Swollen Prostate
__Prostrate Cancer

Genitourinary Female:
__Irregular/painful periods
__Abnormal bleeding
__Discharge
Is there any chance of you being pregnant? Y __ N __

PAST HISTORY

Have you ever experienced your present health concerns in the past? When? _________ What was done? _________________

Have you currently been diagnosed with any illnesses or conditions? Describe ____

Have you in the past been diagnosed with any illnesses or conditions? Describe ____

STRESS SURVEY

Please grade the following stresses in order of increasing intensity.
0 – no awareness of any stress 1 – slightly stressful 2 – moderately stressful 3 – extremely stressful

Overall Physical Stress/Trauma 0 1 2 3
Please check all that apply: ☐ falls, ☐ accidents, ☐ injuries, ☐ impacts, ☐ postural stress, ☐ difficult birth, ☐ traction, ☐ physical abuse
☐ Other ____

Overall Emotional/Mental Stress 0 1 2 3
Please check all that apply: ☐ loss of loved one, ☐ legal concerns, ☐ work related stress, ☐ financial concerns, ☐ stress of being ill, ☐ rapid change in life situation, ☐ change of home/school/job, ☐ relationship stress, ☐ separation/divorce, ☐ mental/emotional abuse
☐ Other ____

Overall Chemical Stress 0 1 2 3
Please check all that apply: ☐ drugs, ☐ smoke, ☐ fumes, ☐alcohol, ☐allergies, ☐ chemical exposure, ☐food additives, ☐ perfumes
☐ Other ____

Is there anything else which may help us to understand you, your history, or your needs that have not been addressed in this survey? Please explain: ____

Thank for choosing A Place for Healing. We are looking forward to helping you develop a healthy spine and nervous system. We are excited about assisting you on your journey to greater health and wellness.