Pro*Wellness* Chiropractic

"Get Well, Stay Well"

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Date: ___/___/___

Name of Person filling out form if other than the patient: ___________________________

Patient Information:

Name: ____SSN#_____/_____/_____

Age: ______ Date of Birth:____/____/____ Male___ Female___

Address: ____

City/State/Zip: ____

E-mail Address: ____

Home Phone#_____________Work Phone#_______________Cell Phone#____________

Best Time and Number to Contact: ____________________

Occupation: ____________________________ Employer's Name: ___________________

Employer's Address: ____

Please Check: Single ___ Married___ Divorced___ Widowed___

Spouse's Name: __________________

Number of Children: ____ Name/Age/Gender(s):_________________________________

____

____

Who may we thank for referring you to Pro*Wellness* Chiropractic? ________________

____

Why This Form is Important
At Pro*Wellness* Chiropractic, we focus on your ability to be healthy. Our goals are to first address the health conditions that brought you to this office and second, to offer you the option of an improved quality of life through "Wellness Care". On a daily basis, we all experience physical, chemical, and emotional stressors that can decrease our overall health. Most times, the effects of these stressors are gradual and are not felt until serious health conditions arise. Answering the following questions will give us a profile of your specific stressors, past and present, and will allows us to better assess your overall health needs.

Addressing What Brought You to This Office

<u>Main Health Concerns</u>:

(Rate each concern on a scale of "1" (Mild) – "10" (Worst Imaginable))

1. Complaint: ____

Rating: _____**Onset Date**: _________**Result of Injury?** Yes___ No___

Symptom Description: ____

____

Please further describe in detail:

This condition is: Staying the Same___ Getting Better___ Getting Worse ___

This condition is interfering with my: Work___ Leisure___ Sleep___ Sports/Exercise___

Positive Mental Attitude___ Hobbies___ Other___ describe: __________________________

Do you have a family history of this or of a similar condition? Yes___ No___

(If yes, describe)____

What have you done for this condition that was of no help? _______________________

____

What have you done for this condition that has helped you feel better? _______________

____

Have you or have you felt the need to make any positive changes in your life due to this condition? (i.e.: eat better, less alcohol/drugs, meditate, less destructive sports/activities, etc…) Describe:____

Other Doctors I have seen for this condition: Chiropractor___ Medical Doctor___ Other___

1. Name/Address:____

   Date: _________ Diagnosis: ____

   Treatment Received: ____

2. Name/Address:____

   Date: _________ Diagnosis: ____

   Treatment Received: ____

2. Complaint: ____

Rating: _____**Onset Date**: _________**Result of Injury?** Yes___ No___

Symptom Description: ____

____

Please further describe in detail:

This condition is: Staying the Same___ Getting Better___ Getting Worse ___

This condition is interfering with my: Work___ Leisure___ Sleep___ Sports/Exercise___

Positive Mental Attitude___ Hobbies___ Other___ describe: ___________________________

Do you have a family history of this or of a similar condition? Yes___ No___

(If yes, describe)____

What have you done for this condition that was of no help? _______________________

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What have you done for this condition that has helped you feel better? _______________

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condition? (i.e.: eat better, less alcohol/drugs, meditate, less destructive sports/activities, etc…) Describe:____

Other Doctors I have seen for this condition: Chiropractor___ Medical Doctor___ Other___

1. Name/Address:____

   Date: _________ Diagnosis: ____

   Treatment Received: ____

2. Name/Address:____

   Date: _________ Diagnosis: ____

   Treatment Received: ____

3. Complaint: ____

Rating: _____**Onset Date**: _________**Result of Injury?** Yes___ No___

Symptom Description: ____

____

Please further describe in detail:

This condition is: Staying the Same___ Getting Better___ Getting Worse ___

This condition is interfering with my: Work___ Leisure___ Sleep___ Sports/Exercise___ Positive Mental Attitude___ Hobbies___ Other___ describe: _____________________________

Do you have a family history of this or of a similar condition? Yes___ No___

(If yes, describe)____

What have you done for this condition that was of no help? _________________________

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What have you done for this condition that has helped you feel better? _______________

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Have you or have you felt the need to make any positive changes in your life due to this condition? (i.e.: eat better, less alcohol/drugs, meditate, less destructive sports/activities,

etc…) Describe:____

Other Doctors I have seen for this condition: Chiropractor___ Medical Doctor___ Other___

1. Name/Address:____

   Date: __________ Diagnosis: ____

   Treatment Received: ____

2. Name/Address:____

   Date: __________ Diagnosis: ____

   Treatment Received: ____

<u>Significant History</u>:

Please check all the symptoms you have ever had, even if they do not appear to be related to your current health concerns:

__Headaches	_Pins and Needles in Legs	__Fainting	__Neck Pain
__Pins and Needles in Arms	__Loss of Smell	__Back Pain	__Loss of Balance
__Dizziness	__Buzzing in Ears	__Ringing in Ears	__Nervousness
__Numbness in Fingers	__Numbness in Toes	__Loss of Taste	__Upset Stomach
__Fatigue	__Depression	__Irritability	__Tension
__Sleeping Problems	__Stiff Neck	__Cold Hands	__Cold Feet
__Diarrhea	__Constipation	__Fever	__Hot Flashes
__Cold Sweats	__Lights Bother Eyes	__Urinary Problems	__Heartburn
__Mood Swings	__Menstrual Pain	__Menstrual Irregularity	__Ulcers

Do you wear orthotics or heel lifts? Yes__ No__

List Any Diagnosed Medical Conditions: ____

____

____

____

List Any Medications/Supplements you are taking and why: (prescription and

non-prescription)____

____

____

____

Accidents and/or injuries: (auto, work related or other)

1. Accident/Injury Description: ____

   Date: _______ Hospitalized? Yes___No___

2. Accident/Injury Description: ____

   Date: _______ Hospitalized? Yes___No___

3. Accident/Injury Description: ____

   Date: _______ Hospitalized? Yes___No___

X-Rays:

Have you ever had X-Rays taken? Yes__No__

Facility where X-Rays were taken________________________________ Date: ___________

Body Part(s) Examined: ____

Surgical History:

1. Type:____

   Date: _________ Doctor: ____

2. Type:____

   Date: _________ Doctor: ____

3. Type:____

   Date: _________ Doctor: ____

<u>Stress:</u>

Please list your top 3 stressors is each category:

A. Physical Stress (falls, accidents, work postures, etc…)

1. ____
2. ____
3. ____

B.Chemical Stress (work,unhealthy foods, missed meals,decreased water intake, drugs, etc…)

1. ____
2. ____
3. ____

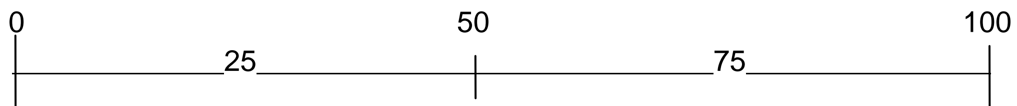
C. Psychological Stress (work, relationships, finances, self esteem, etc…)

1. ____
2. ____
3. ____

On a Scale of 1-10 (1=poor, 10=excellent), describe your habits related to the following:

Eating___ Exercise___ Sleep___ General Health___ Wellness Lifestyle___

Please Rate (0=worst health, 100=best health) where you think you are now (mark with a "0") and where you want to be (mark with an "x"):



<u>Family Health Profile</u>:

At our office, we are not only interested in your health and well-being, but also the health and well-being of your family. Please list below their names and any health conditions they have:

Children: ____

____

Spouse: ____

____

Mother: ____

____

Father: ____

____

Brother(s): ____

____

Sister(s): ____

____

Others: ____

____

I consent to a professional and complete chiropractic examination. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature:____Date:___/___/___

Thank you for filling out this form. It is your first step to “Getting well and Staying Well.”

Return this to our staff and someone will be right with you.