Your Wellness History – Health Profile

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Date: _____

Name: _____ **DOB:** _____ **Age:** _____/ **Male Female**

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Home # ( )_____ **Work: ( )**_____ **Cell: ( )**_____

Best time to contact: _____

Email address: _____ **Status:** Single Married Partnered Divorced Widowed

# of Children: _____ **Names/Age:** _____

Occupation: _____ **Employer Name/Address:** _____

Rate your health and wellness.

Place an '**X**' that denotes where you believe is your current level of wellness.
Place an '**O**' indicating where you would like your wellness to be.

YOUR HEALTH PROFILE

- What brings you into our office today?

Please briefly describe, including the impact it has had on your life. If you're only here for chiropractic wellness services please skip this part and go to "General History" on the next page.

Rate Severity (scale 1-10, 1being mild) When and how did this start? Are symptoms constant or intermittent?

_____

_____

_____

- Since the problem started it is; ___the same ___getting better ___ getting worse

What makes the problem worse?_____

_____

- What, if anything, makes the problem feel better?_____

_____

- Does this interfere with your; ___Leisure ___Work ___Sleep ___Sports ___Other

_____

- Have you seen other doctors for this condition? ___Chiropractor ___MD ___Other

Name/Address: _____ Date: _____

What was the diagnosis: _____

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GENERAL HISTORY

- Please list all medications you are taking, and why; (Prescription and non-prescription)

_____

_____

_____

- Have you had any surgeries and/or hospitalizations? ___Yes ___No

If yes, briefly explain:_____

_____

- Have you ever had any work related injuries? ___Yes ___No

If yes, briefly explain: _____

_____

- Have you ever had any slips, falls or auto accidents? ___Yes ___No

If yes, briefly explain:_____

_____

Please check all symptoms (now or in the past) you have ever had, even if they do not seem related to your current problem.

Current	Past		Current	Past	
❑	❑	Headaches	❑	❑	Irritability
❑	❑	Pins & needles in arms	❑	❑	Cold hands
❑	❑	Pins & needles in legs	❑	❑	Cold feet
❑	❑	Dizziness	❑	❑	Fever
❑	❑	Numbness in fingers	❑	❑	Urinary problem
❑	❑	Fatigue	❑	❑	Fainting
❑	❑	Sleeping problems	❑	❑	Eyes bothered by light
❑	❑	Tension	❑	❑	Stomach upset
❑	❑	Ulcers	❑	❑	Diarrhea
❑	❑	Buzzing in ears	❑	❑	Cold sweats
❑	❑	Ringing in ears	❑	❑	Mood swings
❑	❑	Numbness in toes	❑	❑	Loss of smell
❑	❑	Depression	❑	❑	Loss of taste
❑	❑	Constipation	❑	❑	Back pain
❑	❑	Menstrual pain	❑	❑	Neck pain
❑	❑	Menstrual irregularity	❑	❑	Stiff neck

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YOUR GOALS

➢ On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/psychological/lifestyle stress levels:

Scale =____ Occupational stress: _____

Scale =____ Personal stress: _____

➢ On a scale of 1 to 10 (1 = poor, 10 = excellent), describe your habits and condition as it relates to:

Eating_____ Exercise_____ Sleep_____ General Health_____ Wellness lifestyle_____

Please check all that are relevant.

Do you:	Would you like to know more about:
❑ Water - Drink ½ your body weight in ounces	❑ Proper Nutrition and meal planning
❑ Exercise regularly	❑ Proper exercise routines and techniques
❑ Take vitamins or supplements	❑ How to deal with LifeStyle stress

Wellness Goals

Physical (being fit)	Nutritional (eating right)	Psychological (think well)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Thank you for filling out this form.
It is your first step to Creating Wellness!

I consent to a professional and complete chiropractic examination. I understand that all fee's for services rendered are due at the time of service and cannot be deferred to a later date.

Signature: _____ Date: _____

Please return this form to our staff and someone will be right with you.

Vibrant Living Chiropractic
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