



## I. Personal Information

NAME \_\_\_\_\_ LIKE TO BE CALLED " \_\_\_\_\_ " PATIENT# \_\_\_\_\_ DATE \_\_\_\_\_

MALE  FEMALE AGE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ E-MAIL ADDRESS \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ WORK # \_\_\_\_\_ CELL # \_\_\_\_\_

SINGLE  MARRIED  SIGNIFICANT OTHER  DIVORCED  WIDOWED BEST TIME/# TO CALL \_\_\_\_\_

# OF CHILDREN / DEPENDENTS \_\_\_\_\_ NAME(S) /AGE / GENDER \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER NAME / ADDRESS \_\_\_\_\_

HOW DID YOU FIND US?  REFFERAL (WHO REFERRED YOU) \_\_\_\_\_  INTERNET (Search Engine) \_\_\_\_\_

INSURANCE LISTING  WALK-IN/PASSING BY  PHONE DIRECTORY  MARKETING/EVENT (WHAT -or- WHERE?) \_\_\_\_\_

## II. Your Health Profile

### 1. Why This Form Is Important

As a Creating Wellness Center, we focus on your ability to be healthy. Our goals are to:

- First, address the issues that brought you to this center.
- Second, offer you the opportunity of improved health, wellness and quality of life in the future.

Daily, we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Often, the effects are gradual and are not felt until they become serious. Answering the following questions will give us a profile of the specific stresses - **past and present** - that you face, and help us assess any challenges to your health potential.

### 2. Addressing What Brought You To Our Center

Please briefly describe your chief concern, including the effect it has had on your life:

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3. Health Concerns	SEVERITY	DATE THIS EPISODE STARTED	IF ONGOING, DATE OF LAST EPISODE	DID PROBLEM BEGIN WITH AN INJURY?	ARE SYMPTOMS CONSTANT OR PERIODIC?
LIST HEALTH CONCERNS IN ORDER OF IMPORTANCE	1 = MILD 10 = UNBEARABLE				
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____

If you are experiencing pain, is it:  Dull Ache  Sharp

Does the pain radiate/travel anywhere?  No  Yes - please describe:

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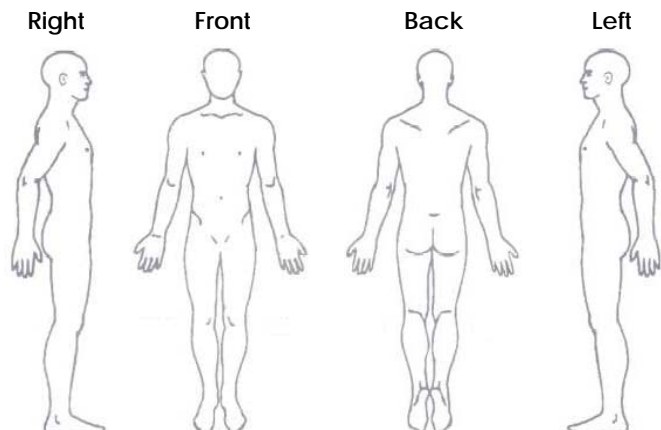
### 4. Show Us Where It Hurts: Please mark area(s) of injury or discomfort as shown in the example below.

1. Mark all areas with the correct symbol. 2. Indicate the degree of pain from 1 (discomfort) to 10 (extreme pain).

**EXAMPLE**

Numbness: **NNN**  
 Pins & Needles: **PPP**  
 Burning: **BBB**  
 Aching: **AAA**  
 Stabbing: **SSS**

Circle any area(s) of pain not detailed with a symbol



Since the problem started, it is:  Getting Better  About the Same  Getting Worse

What makes it worse? \_\_\_\_\_

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

What have you done that hasn't helped? \_\_\_\_\_

I Do  I Do Not Have A Family History of this or similar symptoms (if you do, please explain)

Is this condition interfering with your:

Work  Leisure  Sleep  Exercise / Fitness  Attitude  Hobbies  Other \_\_\_\_\_

Have you thought of and/or felt the need to make any "positive" changes due to this condition?

(i.e. eat better, less alcohol/drugs, meditate, lower intensity exercise etc.) If "yes", what: \_\_\_\_\_

Other Doctors Seen For This Condition:  Chiropractor  Medical Doctor  Other

1. Name/Address: \_\_\_\_\_

Date: \_\_\_\_\_ What was the diagnosis? \_\_\_\_\_

2. Name/Address: \_\_\_\_\_

Date: \_\_\_\_\_ What was the diagnosis? \_\_\_\_\_

Who Is Your Family Doctor/Primary Care Physician?

Name/Address: \_\_\_\_\_

Date Of Last Check Up/Physical: \_\_\_\_\_ Findings: \_\_\_\_\_

### III. General History

Please check all symptoms you have ever had, even if they do not seem related to you current problem:

- |   |   |  |  |
|---|---|--|--|
| <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"/> Ringing in Ears        | <input type="checkbox"/> Back Pain       | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Buzzing in Ears        | <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Depression             | <input type="checkbox"/> Irritability    | <input type="checkbox"/> Tension         |
| <input type="checkbox"/> Sleep 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"/> Sensitivity to Light   | <input type="checkbox"/> Urinary Problem | <input type="checkbox"/> Heartburn       |
| <input type="checkbox"/> Mood Swings            | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Menstrual Pain  | <input type="checkbox"/> Ulcers          |

List any medications you are taking and why: (prescription and non-prescription) \_\_\_\_\_

Please List All Surgeries Below:

1. Type: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_

2. Type: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_

3. Type: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_

**Accidents and/or Injuries: auto, work related, or other (especially those related to your current problem):**

- 1. Type: \_\_\_\_\_ Date: \_\_\_\_\_ Hospitalized  Yes  No
- 2. Type: \_\_\_\_\_ Date: \_\_\_\_\_ Hospitalized  Yes  No
- 3. Type: \_\_\_\_\_ Date: \_\_\_\_\_ Hospitalized  Yes  No

**Have you ever had x-rays taken?**  No  Yes (if "yes") Date: \_\_\_\_\_ Location: \_\_\_\_\_  
Area(s) of body: \_\_\_\_\_

**Please list your top 3 stresses in each category:**

- 1. **Physical Stress** (falls, accidents, work posture, etc.)
  - A. \_\_\_\_\_
  - B. \_\_\_\_\_
  - C. \_\_\_\_\_
- 2. **Bio-Chemical Stress** (smoke, unhealthy foods, missed meals, lack of water, drugs, etc.)
  - A. \_\_\_\_\_
  - B. \_\_\_\_\_
  - C. \_\_\_\_\_
- 3. **Psychological Stress** (work, relationships, finances, self-esteem, etc.)
  - A. \_\_\_\_\_
  - B. \_\_\_\_\_
  - C. \_\_\_\_\_

**IV. The Beginning Years (birth to 17 years)**

Research is showing that many of the health challenges adults face started in the developmental years, often as early as birth. Please answer the following question as honestly and accurately as possible:

	Yes	No	Unsure
1. Did you have any serious childhood illnesses?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Did you have any serious falls as a child?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Did you play youth sports?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Did you take/us any drugs (prescribed or not)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Did you have any surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Did you have any serious accidents?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Did you have prolonged used of medications like antibiotics or inhalers?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Did you suffer any other traumas physical or emotional?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Were you vaccinated?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Did you receive regular Chiropractic care?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Comments:** \_\_\_\_\_  
\_\_\_\_\_

#### IV. Adult Years (18 years - present)

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Do/did you smoke?.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do/did you drink alcohol (more than socially)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you been in an accidents? .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any surgery?.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do/did you play adult sports? .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do/did you play extreme sports? .....               | <input type="checkbox"/> | <input type="checkbox"/> |

On a scale of **1 to 10**, **(1) being very poor**, **(10) being excellent**, rate your:

Diet:	1	2	3	4	5	6	7	8	9	10
Exercise:	1	2	3	4	5	6	7	8	9	10
Sleep:	1	2	3	4	5	6	7	8	9	10
Mind-set:	1	2	3	4	5	6	7	8	9	10
Overall Health:	1	2	3	4	5	6	7	8	9	10
Energy Level:	1	2	3	4	5	6	7	8	9	10

On a scale of **1 to 10**, **(1) being none**, **(10) being extreme**, rate your psychological/emotional stress levels:

Occupational:	1	2	3	4	5	6	7	8	9	10
Personal:	1	2	3	4	5	6	7	8	9	10

#### V. Family Health Profile

At our center, we are interested in the health and well-being of your friends, family and loved ones, in addition to you. Please list their names and any health concerns they may have:

Children: \_\_\_\_\_

Spouse: \_\_\_\_\_

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brothers: \_\_\_\_\_

Sisters: \_\_\_\_\_

Others: \_\_\_\_\_

#### VI. Closing Notes

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Bought bottled water? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Belonged to a health club?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Taken vitamins or minerals?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. If there is a need for dietary changes or nutrients, would you like to be informed?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. If there is a need for specific exercises, would you like to be informed?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. If there is a need for support in the psychological / mind / body / stress dimension of health, would you like to be informed?..... | <input type="checkbox"/> | <input type="checkbox"/> |

I consent to a professional chiropractic examination and to any radiographic (x-ray) examination the doctor recommends. I understand that any fee for service(s) rendered is due at the time of service and cannot be deferred to a later date.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE COMPLETE  
PAGES 5 AND 6  
ONLY IF  
YOU HAD AN ACCIDENT  
(AUTO, WORK-RELATED, ETC.)**

**ALWAYS CHIROPRACTIC & WELLNESS**



# Auto / Work-Related Accident - Page 1 of 2

## 1. About You

NAME: \_\_\_\_\_ PATIENT #: \_\_\_\_\_ Today's Date: \_\_\_\_\_

## 2a. Auto Related Accident

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_  a.m.  p.m. # of people in vehicle: \_\_\_\_\_

1. Did the police come to the accident site?  Yes  No
2. Was a police report filed?  Yes  No
3. Was a traffic violation issued?  Yes  No If "yes", to who? \_\_\_\_\_
4. Were there witnesses?  Yes  No
5. Were you surprised by the impact?  Yes  No

### 6. About your vehicle:

1. Name of the location / street you were traveling on: \_\_\_\_\_
2. Make / Model / Year: \_\_\_\_\_
3. Direction were you heading: \_\_\_\_\_
4. Estimated speed: \_\_\_\_\_
5. Your vehicle was impacted in/at the:  Front  Rear  Right Side  Left Side  Other
6. During impact, you were facing:  Right  Left  Forward  Backward
7. Were you wearing a seat belt?  Yes  No
8. Did your vehicle have airbags?  Yes  No  
If "yes", did they inflate?  Yes  No
9. In relation to the base of your skull, where was the headrest?  
 Above  Below  At base of skull
10. What did your vehicle impact?  Another Vehicle  Other: \_\_\_\_\_
11. Did any part of your body strike anything in the vehicle?  Yes  No  
If "yes", please explain: \_\_\_\_\_

### 7. If another vehicle was involved:

1. Make / Model / Year: \_\_\_\_\_
2. Direction traveling: \_\_\_\_\_
3. Estimated speed: \_\_\_\_\_

8. Please describe the accident: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## 2b. Work Related Accident

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_  a.m.  p.m.

Was accident directly related to work?  Yes  No

1. Please describe the events immediately before and during the accident: \_\_\_\_\_  
\_\_\_\_\_
2. Location/Address of accident: \_\_\_\_\_
3. Were there witnesses?  Yes  No Who? \_\_\_\_\_
4. Did you report accident to your employer?  Yes  No
5. What recommendations did your employer make immediately after you reported accident? \_\_\_\_\_  
\_\_\_\_\_
6. Have you had this type of accident before?  Yes  No
7. To your knowledge, has this type of accident Ever happened in your workplace?
8. In general:
  1. Is your job physically stressful?  Yes  No
  2. Is your job mentally stressful?  Yes  No
  3. Is your workplace noisy?  Yes  No
9. Have you changed jobs in the past year?  Yes  No

# Auto / Work-Related Accident - Page 2 of 2

## 3. After Injury

1. Were you ever unconscious?  Yes  No  
> If "yes", how long? \_\_\_\_\_
2. Describe how you felt immediately after the accident:  
\_\_\_\_\_  
\_\_\_\_\_
3. Have you seen any other doctor?  Yes  No  
> If "yes", how long after the accident? \_\_\_\_\_  
> How did you get there? \_\_\_\_\_  
> Name of Hospital: \_\_\_\_\_  
> Name & Type of Doctor: \_\_\_\_\_
4. Describe any treatment you have received: \_\_\_\_\_  
\_\_\_\_\_
5. Were x-rays taken?  Yes  No
6. Was medication prescribed?  Yes  No
7. Have you worked since this injury?  Yes  No
8. Are your work activities restricted?  Yes  No
9. Check the symptoms resulting from this accident:  
 Dizziness     Sleep issues     Low back pain     Back pain  
 Memory loss     Irritability     Arm/Shoulder pain     Nausea  
 Headache(s)     Fatigue     Numb hands/fingers     Chest pain  
 Blurred vision     Tension     Upset stomach     Leg pain  
 Ringing ears     Neck pain     Shortness of breath     Stiff neck  
 Back stiffness     Numb feet/toes     Other
10. Your condition is:  
 Stable     Improving     Worsening     Varies
11. Rate your comfort level performing these activities:  

	Comfortable	Uncomfortable	Painful
Lying on back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stretching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you retained an attorney?  Yes  No  
If "yes": Name: \_\_\_\_\_  
Phone#: \_\_\_\_\_

## 4. Recovery

To evaluate the effect that continuing work will have on your recovery, please complete the following:

1. How many hours do you work each day? \_\_\_\_\_
2. Please indicate your daily job duties and any activities which you are occasionally asked to perform:  
 Standing     Driving     Operating Equipment  
 Sitting     Twisting     Work With Arms Above Head  
 Walking     Crawling     Typing  
 Lifting     Bending     Stooping     Other
3. What positions can you work in with minimum physical effort and for how long? \_\_\_\_\_  N/A
4. Prior to the injury, were you able to do the same work as other people your age?  Yes  No
5. Can anyone help you with lifting?  Yes  No
6. Can you request light duty in recovery?  Yes  No

## 5. Additional Insurance

### 2nd Insurance Source or Auto Insurance

Type of Insurance: \_\_\_\_\_  
 Insurance Company Name: \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone \_\_\_\_\_ Claim # \_\_\_\_\_  
 Insured's Name \_\_\_\_\_  
 Policy # \_\_\_\_\_ Group# \_\_\_\_\_  
 Insured's SS # \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Insured's Employer: \_\_\_\_\_  
 Insurance Agent's Name: \_\_\_\_\_

**If any of your medical or account information has changed, please let us know.**

**Please know that you are ultimately responsible for payment of your account.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

### OFFICE USE ONLY
