



Health for Life Chiropractic:
A Creating Wellness
Center

WELCOME TO HEALTH FOR LIFE

Personal Information

Name: _____ Age _____ Date _____
 Address: _____
 City/State/Zip: _____
 Home Ph #: _____ Work Ph #: _____ Cell Ph #: _____
 Email Address: _____ Gender: Male Female
 Social Security #: _____ Birth date: _____
 Occupation: _____ Employer Name: _____
 Employer Address: _____ Employer Phone #: _____
 Marital Status: Single Divorced Widowed Married - Spouse's Name _____
 Names/Ages of Children: _____

 Who may we thank for referring you? _____
 What is the reason for consulting our office? _____
 What are you looking for in a Doctor? _____
 Have you been to a Chiropractor before? Y N If Yes, how long has it been? _____

Emergency Contact

Name: _____ Relationship: _____
 Home Ph #: _____ Cell Ph #: _____

Your Health Profile:

At Health for Life, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to our office and second, to offer you the opportunity of improved health, wellness and quality of life. On a daily basis, we all experience physical, biochemical and psychological/ emotional stress that can accumulate and result in serious loss of health potential. The effects are often gradual and may not even be 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 allow us to better assess the challenges to your health potential.

General History

Research shows that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following to the best of your ability.

Childhood Years**Y N Unsure****Y N U**

Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was there any prolonged used of medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you suffer any other traumas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you fallen from a height of over 3ft?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you under regular Chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you involved in any car accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adult**Y N****Y N**

Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Do you play adult sports?	<input type="checkbox"/>	<input type="checkbox"/>
Do/did you drink alcohol more than socially?	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>
Were you involved in any car accidents?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery?	<input type="checkbox"/>	<input type="checkbox"/>

Lifestyle

Exercise	Work Activity	Hobbies/Interest	Habits
Current activity _____ _____	<input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Light Labor <input type="checkbox"/> Heavy Labor	_____ _____ _____	<input type="checkbox"/> Smoking cigs/day _____ <input type="checkbox"/> alcohol drinks/wk _____ <input type="checkbox"/> caffeine drinks/wk _____ <input type="checkbox"/> high stress level
Avg. days per week _____			

On a scale of *Poor, Good or Excellent*, describe your:

Diet _____ Sleep _____ Exercise _____ Overall Health _____

Family Health Profile

At Health for Life, we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please list their names and any health conditions they may have:

Children: _____

Spouse: _____ Mother: _____

Father: _____ Brother(s): _____

Sister(s): _____ Others: _____

Family History (Check all that apply and indicate **S for Self, **F** for Family and **B** for Both)**

<input type="checkbox"/> Cancer	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Migraines	<input type="checkbox"/> Ear infection	<input type="checkbox"/> Fractures
<input type="checkbox"/> Liver disease	<input type="checkbox"/> High/low thyroid	<input type="checkbox"/> Headaches	<input type="checkbox"/> Asthma	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Depression	<input type="checkbox"/> Hernia	<input type="checkbox"/> Herniated disc
<input type="checkbox"/> Seizures	<input type="checkbox"/> Constipation	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Influenza	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> High/Low BP	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Bursitis
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes I or II	<input type="checkbox"/> TMJ pain	<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Obesity	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Menstrual/Prostate	<input type="checkbox"/> Arthritis

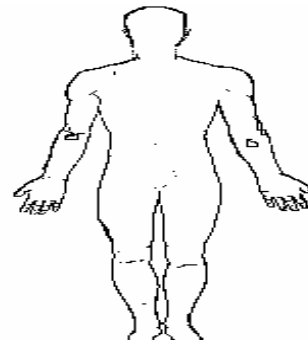
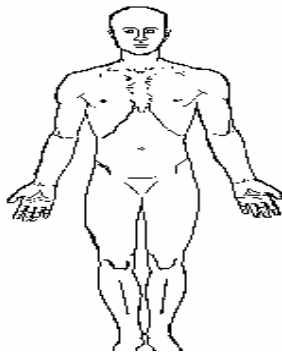
ADDRESSING THE ISSUES THAT BROUGHT YOU TO HEALTH FOR LIFE:

___ Check here if you have no symptoms or complaints and are here for Chiropractic *Wellness* care and skip to the next page. (Stress Profile)

OTHERS, please briefly describe your chief concern, including the effect it has on your life:

Using the body charts below, please indicate where your symptoms are located using the following:

D = Dull Ache **N** = Numbness **T** = Tingling **S** = Sharp Pain **R** = Radiating Pain
 On a scale from **1-10**, please rate the severity of pain for each body part. (1 = minimal pain, 10 = severe pain)



List Health Concerns In order of severity	Rate of Severity 1=mild 0=severe	When did the episode begin?	If you've had this condition before, when?	Did this problem begin w/ an injury?	Are symptoms constant or intermittent?
1.					
2.					
3.					
4.					

Since the problem began, it is.... ___About the same ___Getting better ___Getting worse

What makes the problem worse? _____

What have you tried that makes the problem better? _____

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

This condition interferes with: ___Work ___Sleep ___Walking ___Sitting ___Hobbies ___Leisure

Other Doctors seen for this problem (please list):

___Chiropractor: _____ ___Medical Doctor _____

___Other: _____

Please circle all symptoms you have ever had, even if they do not seem to relate to your current condition.

Allergies	Sinus problems	Upset stomach	Low back pain	Ulcers	Cold hands/feet
Dizziness	Irritability	Gas/Bloating	Urinary problems	Fever	Mood swings
Memory loss	Loss of balance	Acid reflux	Menstrual pain	Tension	Nervousness
Fatigue	Fainting	Irritable bowel	Reproductive problems	Weakness	Hot flashes
Ringing in ears	Neck stiffness	Diarrhea	Loss of bladder control	Spasms	Sweet cravings

Stress Profile

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

Name	Reason	Dosage	Date started

Have you had any surgery? (Please include all surgeries)

- 1. Type _____ Date _____ Doctor _____
- 2. Type _____ Date _____ Doctor _____
- 3. Type _____ Date _____ Doctor _____
- 4. Type _____ Date _____ Doctor _____

Accidents and/or injuries: Auto, work related, or other (*especially those related to your current problems*).

- 1. Type _____ Date _____ Treated? Yes No
- 2. Type _____ Date _____ Treated? Yes No
- 3. Type _____ Date _____ Treated? Yes No

Have you ever had x-rays taken? Yes No If YES, when: _____ where: _____

Area(s) of body x-rayed: _____

Do you wear orthotics or heel lifts? Yes No

Please list your top three STRESSES in each category:

1. Physical stress (falls, accidents, work postures, ect.)

- a. _____
- b. _____
- c. _____

2. Bio-chemical stress (smoking, unhealthy foods, missed meals, don't drink enough water, etc.)

- a. _____
- b. _____
- c. _____

3. Psychological stress (work, relationships, finances, self-esteem, etc.)

- a. _____
- b. _____
- c. _____

I consent to a professional and complete Chiropractic examination and to any radiographic examination that the Doctor deems necessary. 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 Creating Wellness! Return this to our staff and someone will be right with you.