





**YOUR HEALTH/STRESS PROFILE**

|                                       |              |                          |                          |                          |                          |                                   |
|---------------------------------------|--------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------------------------|
| <b>Did you:</b>                       | <b>as a:</b> | <b>Child</b>             | <b>Teenager</b>          | <b>Adult</b>             | <b>None</b>              |                                   |
| Play contact sports                   |              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | on a scale from 1 - 10            |
| Have any serious falls or traumas     |              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | describe your <b>stress level</b> |
| Get involved in any car accidents     |              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | (1 – None / 10 – Extreme)         |
| Have any work injuries                |              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Personal: _____                   |
| Have any surgeries/hospitalizations   |              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Educational: _____                |
| Use medication for extended periods   |              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Occupational: _____               |
| Use street drugs for extended periods |              |                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                                   |
| Drink alcohol                         |              |                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                                   |
| Smoke cigarettes                      |              |                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                                   |

**YOUR MEDICAL HEALTH PROFILE**

Do you suffer from:

**Mind problems** such as:  headaches  sleep disturbance  depression  anxiety  
 fainting  dizziness  balance problems  NONE

**Body problems** involving:  heart, circulation or blood  eyes or ears  joints or bones  
 digestion or stomach  sinuses, nose or throat  muscles or ligaments  
 bowel or bladder  breathing, chest or lungs  foot or ankle  NONE

**Conditions** such as:  skin infections/irritations  allergies  diabetes  hepatitis  cancer  HIV  NONE

List any other medical condition(s) which we should know about? \_\_\_\_\_

**YOUR CURRENT LIFESTYLE PROFILE**

Personal Satisfaction with Diet?  Highly Satisfied  Satisfied  Unsatisfied  Highly Unsatisfied

Do you drink water regularly?  YES  NO, how much? \_\_\_\_\_

Do you exercise regularly?  YES  NO, If YES how often? \_\_\_\_\_  
 what type(s) of exercises? \_\_\_\_\_

Do you take any vitamins, supplements or natural products?  YES  NO,  
 If Yes, Please list: \_\_\_\_\_

Do you take medication on a regular basis?  YES  NO, If Yes Please list:  
 Over the counter: \_\_\_\_\_ Prescription(s): \_\_\_\_\_

**YOUR FAMILY'S HEALTH PROFILE**

At our Office we focus on your health and well-being, as well as the health and well-being of your family and loved ones. Please list the names, ages, and any health condition(s) or concerns your family members may have:

| <u>Name,</u> | <u>age,</u> | <u>condition/concern(s)</u> | <u>Name,</u> | <u>age,</u> | <u>condition/concern(s)</u> |
|--------------|-------------|-----------------------------|--------------|-------------|-----------------------------|
| Spouse       |             |                             | Mother       |             |                             |
| Children     |             |                             | Father       |             |                             |
|              |             |                             | Siblings     |             |                             |

I verify the information provided is true and accurate to the best of my knowledge. I understand I am responsible for the cost of my care and payment is due at the time of service. By signing below, I consent to a complete health history and comprehensive chiropractic examination (including a radiographic examination if deemed necessary by the doctor).

Typed Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Dr.'s Initials: \_\_\_\_\_

We recognize that quality health care is based on a mutual understanding between you and your doctor.  
We invite you to ask any questions you may have regarding your care.