Name: _____ Sex M / F Status S M W D No. Children _____ Date _____

Address _____ City _____ State _____ Zip _____

Telephone: Home _____ Work/Mobile _____ E-mail _____

Social Security # _____ Driver Lic. # _____ Birthdate _____ Age _____

Occupation _____ Employer _____ Years Employed _____

Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Occupation _____ Employer _____ Soc Sec # _____

Person Responsible for this Account _____ Investment By: Cash, Health Plan _____

Subscriber's Name _____ ID # _____ Group # _____

Reason for consulting our office _____

Who may we thank for referring you to our office _____

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

As a Wellness Chiropractic Office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to our office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

THE BEGINNING YEARS (TO AGE 17)

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

YOUR CHILDHOOD YEARS

	YES	NO	UNSURE
Did you have any childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take/use any drugs?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you fallen/jumped from a height over three feet? (i.e., crib, bunk bed, trees)	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	YES	NO	UNSURE
Was there any prolonged use of medicine such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other trauma? (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child were you under regular chiropractic care?	☐	☐	☐
C-Section birth?	☐	☐	☐
Birth complications?	☐	☐	☐

ADULT (18 TO PRESENT)

	YES	NO
Do/did you smoke?	☐	☐
Do/did you drink alcohol?	☐	☐
Have you been in any accidents?	☐	☐
Have you had surgery?	☐	☐

	YES	NO
Do/did you play any adult sport?	☐	☐

On a scale of 1-10 describe your stress level:
(1=none, 10=extreme)

Occupational _____ Personal _____

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

Diet _____ Exercise _____ Sleep _____ General Health _____

On a scale from 1-10 (1=poor, 10=excellent), please rate a time in your life when you were at your peak: _____

How would you rate your present condition 1-10 (1=poor, 10=excellent)? _____

Have you ever:	Yes	No		Yes	No		Yes	No		Yes	No
	Bought bottled water	☐	☐	Belonged to a Health Club	☐	☐	Taken Vitamins or Supplements	☐	☐	Bought organic food	☐	☐

Present: Weight: _____ Height: _____feet _____inches

What do you want to achieve from your care at our office? _____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here _____ **"Wish to have Chiropractic Wellness Services"**, and skip to **"Family Health Profile"**. Others need to briefly describe the areas of chief complaint, including how it began and the effect that it has had on your life. Date problem began ____/____/____. _____

_____

How bad is your problem? 0 (no problem) 1 2 3 4 5 6 7 8 9 10 (unbearable)

How often are your symptoms present? ☐ Constant (100-75%) ☐ Frequent (74-50%) ☐ Occasional (49-25%) ☐ Intermittent (24-0%)

If you are experiencing pain/symptoms is it: ☐ Sharp ☐ Throbbing ☐ Aches ☐ Dull ☐ Gripping ☐ Numbness ☐ Burning ☐ Weakness ☐ Tingling ☐ Soreness ☐ Tingling ☐ Other _____

Since it began, is your problem: ☐ Improving ☐ Getting worse ☐ About the same

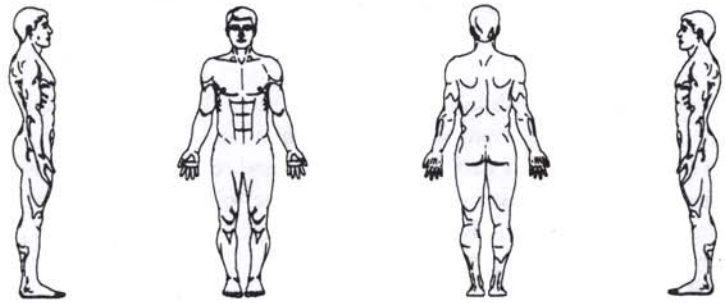
What makes it worse? ☐ Nothing ☐ Stand ☐ Sit ☐ Move ☐ Walk ☐ Lying down ☐ Exercise ☐ Other _____

Yes, it interferes with: ☐ Work ☐ Sleep ☐ Family life ☐ Hobbies ☐ Leisure ☐ Mood ☐ Daily activities ☐ Walking

Other Doctors seen for this problem (please list)

☐ Chiropractic Dr. _____ ☐ Medical Dr. _____ ☐ Other _____

Mark an **X** on the picture where you have pain or other symptoms. Include (P) Pain, (N) Numbness or (T) Tingling:



Please check (✓) all conditions you have ever had, even if they do not seem related to your current problem.

☐ Headaches	☐ Depression	☐ Tension	☐ Irritable Bowel	☐ Hepatitis
☐ Pins/needles in arms/legs	☐ Neck pain	☐ Stomach upset	☐ Hepatitis	☐ Colitis
☐ Dizziness	☐ Neck stiff	☐ Cold feet	☐ Heart attack	☐ HIV/Aids
☐ Fatigue	☐ Constipation	☐ Hot flashes	☐ Stroke	☐ Knee pain
☐ Numbness in fingers/toes	☐ Fainting	☐ Heartburn	☐ Cancer	☐ Ankle pain
☐ Sleeping problems	☐ Low back pain	☐ Ulcers	☐ Diarrhea	☐ Arm pain
☐ Gallbladder/liver problems	☐ Mid back pain	☐ Asthma	☐ Chronic cough	☐ Jaw pain
☐ Cold sweats	☐ Cold hands	☐ Diabetes	☐ Vision problems	☐ Foot pain
☐ Mood swings	☐ Fever	☐ PMS	☐ Sinus problems	☐ Finger pain
☐ Ringing in ears	☐ Menstrual pain	☐ Leg pain	☐ Excessive thirst	☐ Shoulder pain
☐ Menstrual irregularity	☐ Irritability	☐ Hip pain	☐ Prostate problem	☐ Elbow pain
☐ Light bothers eyes	☐ Loss of balance	☐ Hand pain	☐ High blood pressure	☐ Epilepsy
☐ Problem urinating	☐ Nervousness	☐ Wrist pain	☐ Kidney disorders	☐ Other _____

List any medications you are taking: _____

List any hospitalizations/surgeries: _____

FAMILY HEALTH PROFILE

At our office 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 mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Mother _____

Father _____

Brothers _____

Sisters _____

Others _____

I certify that the statements made on this form are complete and accurate to the best of my knowledge. I agree to notify Dr. Termini immediately whenever I have changes in my health condition and agree to allow this office to examine me for further evaluation.

Signature _____ Date _____