



DATE: \_\_\_\_\_

### Personal Information

### Your Health Profile

NAME: \_\_\_\_\_ PATIENT#: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_

LOCAL MAILING ADDRESS: \_\_\_\_\_

CITY / STATE / ZIP: \_\_\_\_\_

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

E-MAIL ADDRESS: \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

OTHER MAILING ADDRESS: \_\_\_\_\_

OCCUPATION \_\_\_\_\_ EMPLOYER'S NAME AND ADDRESS: \_\_\_\_\_

SINGLE: \_\_\_\_\_ MARRIED: \_\_\_\_\_ DIVORCED: \_\_\_\_\_ WIDOWED: \_\_\_\_\_ SPOUSE/PARTNER NAME: \_\_\_\_\_

CHILDREN: NAMES, AGES & GENDER: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

### Your Health Profile

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 office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are 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 .

Are you here for Wellness? \_\_\_\_\_ or A Specific Symptom or Complaint? \_\_\_\_\_

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History ." (next page)

Others, please briefly describe your chief concern, including the effect it has had on your life.

\_\_\_\_\_

Health Concerns: <i>List health concerns according to their severity.</i>	Rate of Severity 1= mild 10= worst imaginable	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

If you are experiencing pain, is it...

- Sharp
- Dull ache
- Tingling
- Numbness

Does the pain radiate anywhere?  yes  no

If yes, where? \_\_\_\_\_

Since the problem started, it is...  About the same  Getting Better  Getting Worse

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

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

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

I do  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  Sports/exercise/walking,

Positive mental attitude  Hobbies  Other \_\_\_\_\_

Have you had to, or felt the need to make any "positive" changes in your life due to your condition? (i.e., eat better, less alcohol or drugs, meditate, less destructive sports, activities, etc.) if so what?

If you felt fully well, what would you like to be doing that you are not doing now?

Other Doctors seen for this condition:  Chiropractor  Medical Dr.  Other

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

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

What was done? \_\_\_\_\_

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

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

What was done? \_\_\_\_\_

## General History:

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

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Neck pain       |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Loss of smell            | <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"/> Numbness in fingers      | <input type="checkbox"/> Numbness in toes         | <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Stomach Upset   |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Depression               | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Tension         |
| <input type="checkbox"/> Sleeping 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"/> Lights bother eyes       | <input type="checkbox"/> Urinary Problem        | <input type="checkbox"/> Heartburn       |
| <input type="checkbox"/> Mood Swings              | <input type="checkbox"/> Menstrual Pain           | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers          |

List any medications you are taking and why: **prescription** and **non-prescription** (vitamins, herbs, homeopathics...)

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

Type: \_\_\_\_\_ Date: \_\_\_\_\_ Doctor: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Accidents and/or injuries: auto, work related, or other (especially those related to your present problems).

1. Type \_\_\_\_\_ Date \_\_\_\_\_ Hospitalized  Yes   
2. Type \_\_\_\_\_ Date \_\_\_\_\_ Hospitalized  Yes   
3. Type \_\_\_\_\_ Date \_\_\_\_\_ Hospitalized  Yes

Have you ever had x-rays taken? (if yes) When: \_\_\_\_\_ Where: \_\_\_\_\_

Area of body: \_\_\_\_\_

Do you wear orthotics or heel lifts?  Yes  No

**We have found that there are 6 interferences to full health and wellness. While you may feel only a physical pain or symptom, please answer the following about these 6 interferences:**

1. Physical:

1. Any recent trauma, falls, sports injuries? \_\_\_yes \_\_\_no  
if yes, explain: \_\_\_\_\_  
2. Do you have any scars on your body (from surgeries or injuries)? \_\_\_yes \_\_\_no  
if yes, explain: \_\_\_\_\_

2. Nutrition:

1. Current habits: \_\_\_smoking \_\_\_alcohol \_\_\_soda \_\_\_broccoli \_\_\_white sugar  
\_\_\_caffeine \_\_\_meat \_\_\_missed meals \_\_\_other \_\_\_\_\_  
2. Do you feel you need some coaching with your nutrition/diet/food plan? \_\_\_yes \_\_\_no

3. Electromagnetics:

1. Do you use: \_\_\_cell phone \_\_\_computer \_\_\_microwave oven \_\_\_hair dryer \_\_\_TV  
\_\_\_video games \_\_\_portable electronic devices \_\_\_other \_\_\_\_\_  
2. How many hours per week do you spend at a computer? \_\_\_\_\_  
3. Do you live near power lines? \_\_\_yes \_\_\_no

4. Toxins:

1. Do you have any teeth fillings? \_\_\_yes \_\_\_no If yes, are they: \_\_\_metal \_\_\_ceramic  
2. Are you exposed to any chemicals on a regular basis? \_\_\_gasoline \_\_\_oil \_\_\_lead \_\_\_solvents  
\_\_\_paint/paint thinner \_\_\_cleaning solutions \_\_\_antiperspirant with aluminum \_\_\_Aluminum cookware  
\_\_\_nail polish/remover \_\_\_Teflon coated cookware \_\_\_other: \_\_\_\_\_

5. Allergies/Sensitivities:

1. Do any foods bother your digestion? \_\_\_yes \_\_\_no. If yes, what? \_\_\_\_\_  
2. Have you had any food/allergy testing? \_\_\_yes \_\_\_no  
3. Do you have any airborne allergies? \_\_\_dust \_\_\_pollen \_\_\_mold \_\_\_other: \_\_\_\_\_  
4. Do you have any food cravings? \_\_\_yes \_\_\_no. If yes, what? \_\_\_\_\_

6. Emotions/Psychological:

- 1. Have you had any recent stressful events? \_\_\_ death of loved one or pet \_\_\_ move \_\_\_ job change  
\_\_\_ other: \_\_\_\_\_
- 2. Do you tend to feel stress in your body? \_\_\_ yes \_\_\_ no.  
If yes, where? \_\_\_ neck \_\_\_ back \_\_\_ headaches \_\_\_ digestion \_\_\_ other: \_\_\_\_\_
- 3. Do you find any aspects of your life stressful? \_\_\_ work \_\_\_ family \_\_\_ relationships \_\_\_ finances  
\_\_\_ other: \_\_\_\_\_

On a scale of 1-10, (1 being very poor / low & 10 being excellent / high) describe your:

Eating Habits: \_\_\_\_\_ Exercise Habits: \_\_\_\_\_ Sleep: \_\_\_\_\_ General Health: \_\_\_\_\_  
 Mind Set: \_\_\_\_\_ Personal Stress: \_\_\_\_\_ Job Stress: \_\_\_\_\_

**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 list below their names and any health conditions or concerns they may have:

Children: \_\_\_\_\_ Brothers: \_\_\_\_\_  
 Spouse: \_\_\_\_\_ Sisters: \_\_\_\_\_  
 Mother: \_\_\_\_\_ Others: \_\_\_\_\_  
 Father: \_\_\_\_\_

**Insurance Information:**

Do you have health insurance: \_\_\_ yes \_\_\_ no If yes, please give us your insurance card(s) to copy.

**\*\*Please note that it is YOUR responsibility to find out if you have chiropractic coverage on your Policy and what the deductible and copayment amounts are.**

Was **this** injury the result of an accident? \_\_\_ yes \_\_\_ no

If yes: \_\_\_ work \_\_\_ auto \_\_\_ other: \_\_\_\_\_ Date of accident: \_\_\_\_\_

\_\_\_\_\_(initial) \*\* I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary report forms and assist me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

\_\_\_\_\_(initial) We require you leave a credit card number on file so that any balances over 30 days can be automatically charged to it.

Credit Card # \_\_\_\_\_ exp. \_\_\_\_\_

\_\_\_\_\_(initial) \*\* I acknowledge that I have read and understand Lowey Chiropractic's Office Policies, Informed Consent, and Privacy Pledge.

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.