



2090 Dunwoody Club Drive, Suite 103
Atlanta, GA 30350

Personal Information

Name: _____ Patient # _____ Age: _____ Date: _____

Address: _____

City/State/Zip: _____

Home Phone#: _____ Work Phone #: _____ Cell Phone #: _____

Email Address: _____ Social Security No.: _____

Birthdate: _____ Best time & No. to Contact: _____

Occupation: _____ Employer's Name and Address: _____

Single: _____ Married: _____ Divorced: _____ Widowed: _____ Other: _____

No. of Children: _____ Names and Genders: _____

Who may we thank for referring you to our office? _____

Your Health Profile

Why is This Form Important?

As a Wellness Chiropractic 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. Answering the following the questions will give us a profile of specific stresses past and present that you face and allow us to better assess the challenges to you health potential.

Addressing what brought you to this office:

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

<u>Health Concerns:</u> Reasons for your visit today based on their severity	Rate of Severity 1= mild 10 = worst Imaginable	When did this episode start?	If you had the condition before,	Did problem begin with an injury? when?	Are your symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

If you are experiencing pain, is it...(circle most applicable) [Sharp/Shooting] [Dull Ache] [Tingly] [Pins & Needles]

Does the pain travel/radiate anywhere: [no] [yes] - please describe if yes

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] [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] [Sports/exercising/walking] [Hobbies]
[Positive mental attitude] [Other]: _____

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

Other doctors seen for this condition: [Chiropractic] [Medical Dr.] [Other]: _____

1. Name/Address: _____
Dates: _____ What was the diagnosis _____

2. Name/Address: _____
Dates: _____ What was the diagnosis _____

General History

Please check [x] all symptoms you have ever had, even if they do not seem to relate 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"/> Loss of smell | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Irritability | <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Tension | <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Stomach Upset | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Depressions | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Lights bother eyes |
| <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Back pain | <input type="checkbox"/> Loss of balance |

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

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

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 present problems).

1. Type: _____ Date: _____ Hospitalized: [yes] [no]
2. Type: _____ Date: _____ Hospitalized: [yes] [no]
3. Type: _____ Date: _____ Hospitalized: [yes] [no]

The Beginning Years

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

Birth to 17 years of age	Yes	No	Unsure
Did you have any serious childhood illnesses?	<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"/>
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you take/use any drugs (prescribed or not)	<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 involved in any car accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was there prolonged use of medication such as: Antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you suffer any other traumas such as: Physical?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you under regular chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dr. COMMENTS: _____

Adult (18 to present)	Yes	No
Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do/did you drink alcohol (more than socially)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear orthotics or heel lifts?	<input type="checkbox"/>	<input type="checkbox"/>
Do you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>
Do/did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>

On a scale of 1 - 10 describe your psychological/emotional stress levels: (1 = none, 5 = moderate, 10 = extreme)

Occupational: _____

Personal: _____

On a scale of 1 - 10, (1 = very poor, 5 = average, 10= excellent/perfect) describe your:

Eating habits: _____

Exercise habits: _____

Sleep: _____

General Health: _____

Mind-set: _____

