ACTIVE BODY CHIROPRACTIC

PERSONAL HEALTH PROFILE

Name:			Date:
Home Address:		City:	Postal Code:
E-mail Address:		Home Phone: ( )	Work Phone: ( )
Gender: ❒ M ❒ F	Marital Status: ❒Single ❒Married ❒Divorced ❒ Common law ❒ Widowed	Cell Phone: ( )	
Date of Birth: MM DD YY	Age:	Occupation:	Employer:
Work address:		City:	Postal Code:
Extended Health Insurance: ❒ No ❒ Yes Company:		$ Participation / Year:	Renewal Date (i.e. Jan 1):
How were you referred to our office?		Have you ever received chiropractic care before? ❒ No ❒ Yes Date of last visit? Who was the Doctor? _____Years under care? Where was the Doctor?	
Spouse's Name:		Spouse's Occupation:	
Do you have children? ❒ No ❒ Yes	What are your children's names/ages?	If you are under 18, what are your Parents' names?	

Present State of Health

Years of continuing damage show up as acute or chronic symptoms.

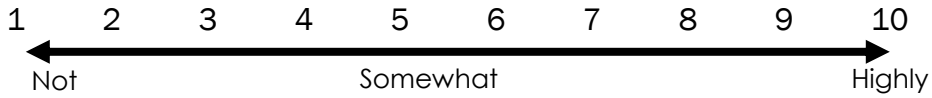
Is this visit for a wellness checkup? ❒yes ❒no . If this is for a specific concern, proceed below:

	Primary concern	Secondary concern
Specific concern(s) and location		
How long have you had this?		
How would you describe the pain?	❒ sharp ❒ dull ❒ achy ❒ pins/needles ❒ burning ❒ numb	❒ sharp ❒ dull ❒ achy ❒ pins/needles ❒ burning ❒ numb
How often does this happen?	❒ constant ❒ on/off ❒ daily	❒ constant ❒ on/off ❒ daily
Place an X on the grade to indicate the severity of your pain.	Least 1 2 3 4 5 6 7 8 9 10 Worst	Least 1 2 3 4 5 6 7 8 9 10 Worst
What makes it worse? (sitting, standing etc)		
What have you tried to address this concern?		
At its worst, this problem interferes with:	❒ ability to work ❒ hobbies/sports ❒ family/social time ❒ sleep ❒ daily activities	❒ ability to work ❒ hobbies/sports ❒ family/social time ❒ sleep ❒ daily activities

If you don't get the problem corrected, it will get worse in the next ❒ 1 year ❒ 2 years ❒ 5 years?

Besides getting rid of the above concern, what is your main reason for wanting to get better/be healthy?
*(e.g. exercise, family, job, live longer, live easier)*_____

On a scale of 1 to 10 (10 being the highest), rate your commitment to improving your health *(circle number):*



History

Let's begin at birth when you may have first damaged your nervous system, lost your wellness and began a journey to ill health.

Birth, Growth and development
Have you been a victim of birth trauma like:
❒ long and/or difficult ❒ forceps ❒ vacuum extraction ❒ caesarean ❒ breech ❒ epidural ❒ induced
❒ Natural (no drugs or pulling/excessive force) ❒ don't know?

Did you get checked regularly by a chiropractor as a child? ❒ yes ❒ no

Traumas and stresses
In your whole life, what were your 5 most serious physical traumas/stresses (eg. automobile jarring/impacts, work stress, recreational activities, sports, falls, fractures)

Trauma	Date of trauma	Office use
1)		
2)		
3)		
4)		
5)		
6)		
7)		

Mental/Emotional stress levels (1 → 10, 10 being high): _____ Caused by ❒ work ❒ home ❒ family ❒ other_____

Have you ever been hospitalized? If so, please describe _____

What surgeries have you had? _____
What medications/chemicals are you currently taking? _____
What medications/chemicals have you taken in the last 5 years? _____

Check off any of the following bodily warning signs that apply to you.
If you have experienced them in the past, please circle them.

- ❒ Tension/Headaches
- ❒ Mid Back Pain
- ❒ Neck Pain
- ❒ Tension Across Top of Shoulder
- ❒ Pain Between Shoulders
- ❒ Numbing/Tingling in Arms/Hands
- ❒ Wrist/Hand pain
- ❒ Chest Pain
- ❒ Heartburn
- ❒ High/Low Blood Pressure
- ❒ Elevated cholesterol
- ❒ Poor Posture
- ❒ Dizziness
- ❒ Blurred/Failing Vision
- ❒ Deafness/Ears Ringing
- ❒ Earaches/Ear infections
- ❒ Low Back Pain
- ❒ Numbing/Tingling in Legs/Feet
- ❒ Hip Pain
- ❒ Iliotibial Band Syndrome
- ❒ Knee Pain
- ❒ Foot Pain
- ❒ Shin Splints
- ❒ Arthritis/Swollen Joints
- ❒ Allergies / Infections
- ❒ Digestive Problems
- ❒ Ulcer
- ❒ Diabetes
- ❒ Bladder Problems
- ❒ Thyroid Problems
- ❒ Weight Trouble
- ❒ Breathing Problems
- ❒ Asthma
- ❒ Immune Problems
- ❒ Frequent Colds/Flu
- ❒ Heart Problems
- ❒ Difficulty Sleeping
- ❒ Anxiety/Depression
- ❒ Poor Concentration/Memory
- ❒ Sexual Dysfunction
- ❒ Infertility
- ❒ Cancer

Other Health Concerns:

_____

Women Only:

- ❒ Currently Pregnant
- ❒ Excessive Cramping/Pain
- ❒ Excessive Menstruation
- ❒ Irregular Cycle
- ❒ Hot Flashes
- ❒ Breast Pain/Lumps
- ❒ Date of last menstrual period:___ /___ /___

Many health concerns are related through family members. What health concerns has your family experienced?

Children _____ Spouse/Partner _____ Parents _____

_____ _____ _____

_____ _____ _____

ACTIVE BODY
CHIROPRACTIC

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X-Ray Consent Form

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. We would like to make you aware that x-rays may be required in order to administer your treatment. Any x-rays performed in our office require patient consent before they are to be administered.

I understand that my doctor may need x-rays in order to diagnose my condition and I give permission of all needed diagnostic tests.

Signature: _____ Date: _____

Print name: _____

Females only: Pregnancy Release Form

The radiation used in x-ray may be harmful to an unborn child/developing fetus, especially in the first trimester. To help prevent the accidental irradiation of an unrecognized pregnancy and in accordance with national standards, we require the following information of female patients of child-bearing age.

Name (please print): _____

Date of your last menstrual cycle: _____

Birth control measures: _____

Is there a chance you may be pregnant? _____

Please circle if applicable: I have had a hysterectomy/ tubal ligation

I have been fully informed of the risks involved in radiation of a first trimester pregnancy and assume responsibility for any consequences from the procedures I am about to have. I understand I will not hold Active Body Chiropractic or my doctor responsible for any potential harm to myself of my unborn child. By signing below I consent to the necessary x-ray procedures.

Signature: _____ Date: _____