Adult Wellness Profile

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Practice Member Information _____ File _____

Name: _____
Appointment Date M _____ D _____ 20 _____ Birth Date M _____ D _____ Y _____
Home Address: _____
City _____ State _____ Zip _____
Home Phone: _____ May we leave a message? ☐ Yes ☐ No
Cell Phone: _____ May we leave a message? ☐ Yes ☐ No
Work Phone: _____ May we leave a message? ☐ Yes ☐ No
Email: _____
May we add you to our email newsletter and calendar of events? ☐ Yes ☐ No (Your email will not be shared)
Spouse's name? _____
Name(s) and age(s) of children: _____ _____ _____ _____
Occupation: _____
Do you primarily: ☐ Sit ☐ Stand ☐ Perform repetitive tasks
How did you hear about us? _____

Healthcare History

Have you had previous chiropractic care? ☐ No ☐ Yes
Who was your previous Chiropractor? _____
Where? _____ When? _____
Were X-rays taken in the last 6 months? ☐ Yes ☐ No
What was the primary reason for consulting that office?
☐ Relief Care - Symptom relief of pain or discomfort
☐ Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues
☐ Wellness Care - Maximizing the body's ability for optimal healing and function
Do you feel your previous chiropractic care was effective? ☐ No ☐ Yes
Please explain: _____
Are you wearing: ☐ Heel Lifts ☐ Custom Orthotics
Family Doctor: _____
Date and reason of last visit: _____
May we contact your family doctor regarding your care at our office if necessary? ☐ No ☐ Yes
Naturopathic Doctor: _____
Date and reason of last visit: _____

Other Specialists and healthcare professionals:
Name: _____
Professional Designation: _____
Date and reason of last visit: _____
Name: _____
Professional Designation: _____
Date and reason of last visit: _____

Wellness Profile

Do you have a specific concern that brings you in?
☐ No, I'm interested in having my nervous system assessed to achieve optimal health and functioning.
☐ Yes: _____

If yes, please answer the following questions:

What is your primary area of complaint today? _____
How long have you been aware of this? _____days _____ weeks _____ months _____ years
Where else does this pain go in your body? _____
How often do you experience this? ☐daily ☐weekly ☐monthly ☐comes and goes ☐constantly
On a scale of 1 to 10 (10 being the worst), how does it feel when it's at its worst? _____
How would you describe the pain/discomfort?
☐Dull ☐Achy ☐Throbbing ☐Stabbing ☐Tight/Stiff ☐Burning ☐Sharp ☐Other _____
What makes it feel worse? _____
What makes it feel better? _____
Do you notice any other problems in your body when you get this pain/discomfort? _____
Do you feel your condition getting progressively worse? ☐No ☐Yes
Do you feel your condition can be healed? ☐No ☐Yes
What have you tried that ***has*** helped? ☐Ice ☐Heat ☐Medication ☐Massage ☐Physical Therapy ☐Chiropractic
☐Other _____
What have you tried that ***hasn't*** helped? ☐Ice ☐Heat ☐Medication ☐Massage ☐Physical Therapy ☐Chiropractic
☐Other _____

See additional ***Spinal Nerve Function Form*** to provide further detail on your *Wellness Profile* (***Page5***)

Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate nervous system. The result is a condition called a ***Vertebral Subluxation.*** The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine which may be impeding your body's ability to heal.

Physical

Height _____ Weight _____
Are you happy with your current physical appearance and abilities? ☐Yes ☐No
Frequency of exercise/week: Cardio? . . . . . ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7
Weight bearing?. ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7
Do you stretch after exercise or after other activities of poor posture? ☐Yes ☐Sometimes ☐No
Hours of sleep/night? ☐>6 ☐7-9 ☐10+
Do you feel refreshed upon waking? ☐Always ☐Sometimes ☐Rarely
Age of mattress? _____ Do you feel your mattress is appropriate for your sleeping style? ☐No ☐Yes
Which position do you sleep? ☐Back ☐Belly Side: ☐Right ☐Left ☐Both
Number of hours spent commuting/week? ☐0-2 ☐3-5 ☐6-8 ☐9-11 ☐12+
Number of hours spent at a desk or computer/week? ☐0 ☐1-5 ☐6-10 ☐11-20 ☐21-40 ☐41+
Number of hours spent on smart device/tablet/week? ☐0 ☐1-5 ☐6-10 ☐11-20 ☐21-40 ☐41+
Do you perform any repetitive tasks at home or at work? ☐No ☐Yes
Have you ever been hospitalized or had surgery? ☐No ☐Yes If yes why and when? _____
_____
Have you ever been in a motor vehicle accident (even if it was minor)? ☐No ☐Yes
If yes, what kind and when? _____
Were you evaluated and treated after each accident? ☐ No ☐Yes
Have you had any non-vehicle accidents or falls? ☐No ☐Yes _____

Early Years

To your knowledge, was your delivery difficult? ☐No ☐Yes
☐If yes: ☐Forceps ☐Vacuum ☐Caesarean ☐Breech ☐Other_____
Were you breast fed? ☐No ☐Yes For how long? _____
Did you experience emotional trauma as a child? ☐No ☐Yes _____
Were you ever given antibiotics as a child? ☐No ☐Yes _____
Did you ever have ear infections as a child? ☐No ☐Yes _____
Any major childhood illness? ☐No ☐Yes _____

Emotional

Rate your current level of ***personal stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***relationship stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***financial stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***health stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***family stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Rate your current level of ***career stress*** in your life: . . . . . ☐None ☐Low ☐Moderate ☐High
Do you feel you have a supportive network of friends and family? . . . ☐Yes ☐No
Do you feel you have healthy coping strategies for life stress? . . . . . ☐Yes ☐No

Chemical

Were you vaccinated as a child? . . . . . ☐No ☐Yes
Any adverse reactions to vaccines? . . . . . ☐No ☐Yes_____
Do you choose to have annual flu shots? . . . . . ☐No ☐Yes
Do you take antibiotics? . . . . . ☐No ☐Yes, How often? _____
How many glasses of water/day:. . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of caffeinated beverages/day: . . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
How many glasses of cow's milk, juice and pop/day: . . . . . ☐0 ☐1-3 ☐4-6 ☐7-9 ☐10+
Do you eat gluten?. . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat dairy? . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat refined sugars? (white sugar, white bread and pasta) . . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you eat boxed/frozen foods?. . . . . ☐No ☐Yes ☐Trying to eliminate from diet
Do you choose organic foods?. . . . . ☐No ☐Yes, which: ☐Veggies ☐Fruits ☐Meats ☐Grains ☐All
Do you eat any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc) . ☐No ☐Yes
Any food/drink allergies, sensitivities, intolerances?. . . . . ☐No ☐Yes_____
Do you smoke? . . . . . ☐No ☐Yes ☐I used to for__ years ☐I wish I didn't
Are you or have you been exposed to second hand smoke? . . . . ☐No ☐Yes
Do you drink alcohol? . . . . . ☐No ☐Yes ☐0-6/week ☐6-12/week ☐12+/week
Do you take a probiotic daily?. . . . . ☐No ☐Yes, _____ CFU's/day
Do you take vitamin D3 daily?. . . . . ☐No ☐Yes, _____ IU's/day
Do you take Omega 3 Fish Oils daily?. . . . . ☐No ☐Yes, _____ mg/day ☐Capsule ☐Liquid
Other supplements or homeopathics? _____
Any other daily medication and their purpose? _____
_____
Do you have a plan in place with your medical doctor to wean yourself off of any long term medications? ☐No ☐Yes

Family Health

At our clinic we are not only interested in your health and wellness, but also the health and wellness of the important people in your life. Please mention below any health conditions or concerns you may have about your:

Children: _____
Spouse: _____
Mother: _____
Father: _____
Brothers/Sisters: _____

Are you seeking chiropractic care today for:

- ☐ Relief Care - Symptom relief of pain or discomfort
- ☐ Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues
- ☐ Wellness Care - Maximizing the body's ability for optimal healing and function of the nervous system

Do you have other concerns we should know about? _____

_____
_____
_____
_____
_____
_____
_____
_____
_____

Goals & Consent

What is your primary goal for consulting our clinic? _____

Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at its absolute peak potential. Essential to this is a healthy nervous system functioning free from interference called subluxations. You've taken an important step for your health through a chiropractic evaluation!

Consent to Evaluation

I _____ hereby grant permission to receive a chiropractic evaluation including history, spinal scan and examination. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____
Consenting Adult's Signature Date

Review of Systems
Function of Spinal Nerves

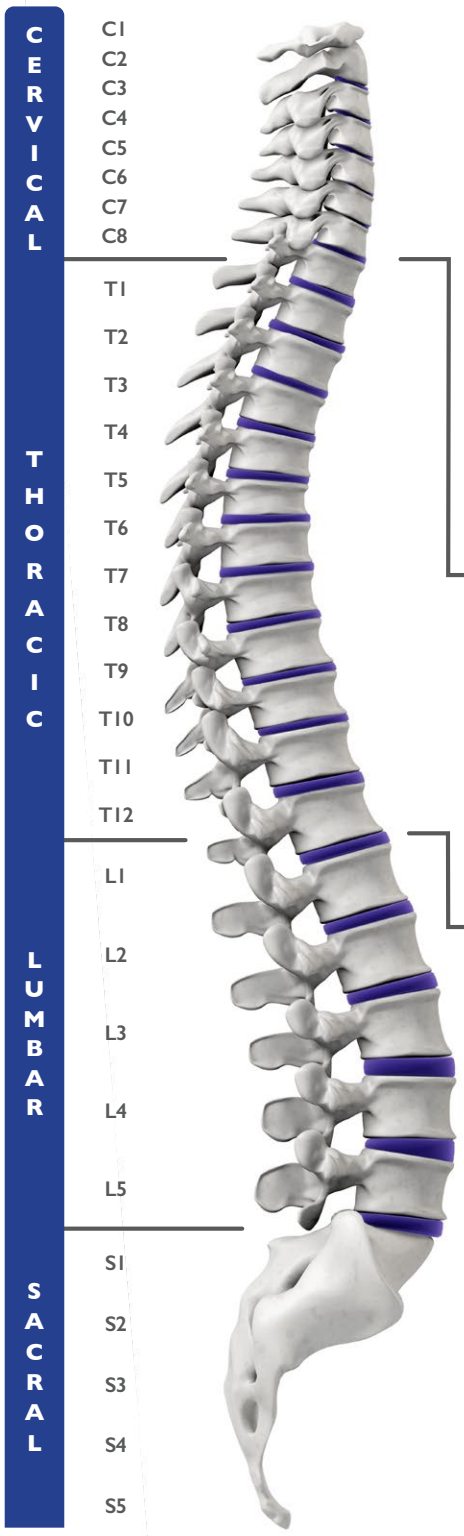
SPINAL NERVE

ORGANS & GLANDS

The organs and glands listed below are linked to the corresponding sections of the spine and it's spinal nerves.

ASSOCIATED SYMPTOMS

Please indicate below any symptoms you are currently experiencing as well as any you have previously experienced.



Parotid Gland • Scalp
Base of Skull • Eyes
Lacrimal Gland • Sinuses
Inner, Middle & Outer Ear
Nose • Mouth
Intracranial Blood Vessels
Sympathetic Nervous System
Neck Muscles • Diaphragm
Shoulders • Elbows • Arms
Wrists • Hands & Fingers
Tonsils • Vocal Cords
Esophagus • Heart
Lungs • Chest • Thyroid

CURRENT	PREVIOUS	
☐	☐	Sinus & Ear Pain/Infection
☐	☐	Runny Nose & Allergies
☐	☐	Frequent Head Colds
☐	☐	Sore Throat & Tonsilitis
☐	☐	Strep Throat
☐	☐	Chronic Cough & Croup
☐	☐	Difficulty Breathing
☐	☐	Poor Immunity
☐	☐	Dizziness & Vertigo
☐	☐	Tinnitus & Ear Fullness
☐	☐	Vision Problems
☐	☐	Watery/Dry Eyes
☐	☐	Chronic Fatigue
☐	☐	Poor Concentration
☐	☐	Depression

CURRENT	PREVIOUS	
☐	☐	Anxiety & Stress
☐	☐	Seizures
☐	☐	ADD/ADHD
☐	☐	Thyroid Dysfunction
☐	☐	Metabolic Dysfunction
☐	☐	Insomnia
☐	☐	High/Low Blood Pressure
☐	☐	Enlarged Lymph Glands
☐	☐	Migraines & Headache
☐	☐	TMJ Pain
☐	☐	Stiff Neck
☐	☐	Arm Pain
☐	☐	Hand/Finger Numbness
☐	☐	Loss of Grip Strength

Arms • Wrists
Esophagus • Chest • Heart
Lungs • Trachea • Larynx
Diaphragm • Stomach
Gallbladder • Liver
Pancreas • Small Intestine
Spleen • Kidneys • Appendix
Adrenals • Colon • Buttocks
Uterus • Ovaries • Testes

CURRENT	PREVIOUS	
☐	☐	Asthma
☐	☐	Bronchitis & Pneumonia
☐	☐	Congestion
☐	☐	Reflux & GERD
☐	☐	Indigestion & Heartburn
☐	☐	Stomach Pains
☐	☐	Ulcers
☐	☐	Gas & Bloating
☐	☐	Jaundice
☐	☐	Liver Conditions
☐	☐	Blood Sugar Dysregulation

CURRENT	PREVIOUS	
☐	☐	Kidney Stones
☐	☐	Gall Bladder Attacks
☐	☐	Skin Conditions & Rashes
☐	☐	Menstrual Cramps/PMS
☐	☐	Infertility
☐	☐	Menstrual Dysfunction
☐	☐	Rashes & Eczema
☐	☐	Hyperactivity
☐	☐	Shoulder Pain
☐	☐	Midback Pain
☐	☐	Rib Pain

Large Intestine • Colon
Thighs • Buttocks • Groin
Knees • Legs • Feet
Reproductive Organs

CURRENT	PREVIOUS	
☐	☐	Irritable Bowel, Colitis, Crohn's
☐	☐	Gas Pain & Constipation
☐	☐	Diarrhea
☐	☐	Hemorrhoids
☐	☐	Bladder Infections
☐	☐	Bladder Incontinence & Bedwetting
☐	☐	Painful/Excessive Urination

CURRENT	PREVIOUS	
☐	☐	Prostate Dysfunction & Impotence
☐	☐	Ovarian Cysts & Endometriosis
☐	☐	Fertility Problems/ Loss of Menstruation
☐	☐	Low Back Pain
☐	☐	Hip Pain
☐	☐	Thigh Pain
☐	☐	Numbness & Tingles in Legs

Buttocks • Groin • Legs
Ankles • Feet • Toes
Prostate Gland • Bladder
Reproductive Organs

CURRENT	PREVIOUS	
☐	☐	Varicose Veins
☐	☐	Leg Cramping
☐	☐	Restless Legs
☐	☐	Poor Circulation & Cold Feet

CURRENT	PREVIOUS	
☐	☐	Sciatica
☐	☐	Pelvic Pain
☐	☐	Knee Pain
☐	☐	Ankle Pain & Sprains
☐	☐	Foot Pain & Weak Arches