Anchor Chiropractic Center

YOUR CONFIDENTIAL HEALTH PROFILE

(Please Print)

Full Name ____ Date_______________________

Mailing Address ____
Street City State Zip

Home Phone ( ) _____-_________Work Phone ( ) _____-_________ Cell Phone ( ) _____-_______________

E-mail Address ___________________________________

Marital Status: M S W D Age________ Birth Date ______________ No. of children ________

Pregnant? ________ Height ________ Weight ________

Occupation __________________________________Employer's Name __________________________________

Spouse/Guardian's Name/Occupation____

WHO MAY WE THANK FOR REFFERING YOU?____
(How did you hear about us?)

Contact in case of an emergency ____

Why This Form is Important

As a Wellness Center, we focus on your ability to be healthy. Our goals are to first address the issues that brought you art into 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 attacks 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 the two faiths and allow us to better assess the challenges to your health potential.

What is your main objective/goal for your health in consulting our office.______________________________

____

What would you like to gain from wellness chiropractic care.____

____

Most of our expert practice members experience positive results with their health concerns within the first four to six weeks of care. If this were to happen for you as well, would you be willing to do what is necessary to keep those changes in your health status? ☐ Yes ☐ No

Are you interested in: ☐ temporary relief or ☐ permanent solutions to your health concerns? *(Check One)*

Are you healthier today than you were five years ago? ☐ Yes ☐ No If not what has contributed to the decline in your health?____

____

Will you be healthy five years from now than you are today? ☐ Yes ☐ No If yes, what are the things you will do to make that happen?____

____

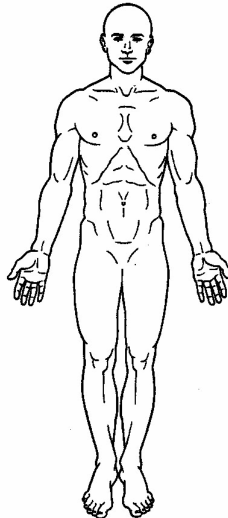
Addressing What Brought You to This Office

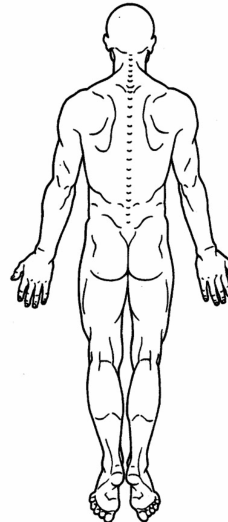
If you have no symptoms or complaints and are here for chiropractic wellness services, please skip to the General History. Otherwise, please describe briefly your chief concern and continue on to the next page

1. HEALTH CONCERNS List health concerns according to their severity. ***(Where Does it Hurt?)*** *What is bothering you?*	**Rate of severity** 1 = mild 10= worst imaginable (Give us a number)	**When did this episode start?** (a week, a month, a year, or specific date)	**If you had the condition before? when?** (Yes/No, a week, a month, a year, or specific date)	**Did problem begin with injury?** (Yes/No)	**% of time pain is present**
1. ______________________	________	________	________	________	________
2. ______________________	________	________	________	________	________
3. ______________________	________	________	________	________	________
4. ______________________	________	________	________	________	________
5. ______________________	________	________	________	________	________

Please circle and mark your areas of pain on the figures

Numbness = **N**
Tingling = **T**
Burning = **B**
Stiffness = **D**
Stabbing =**S**
Aching = **A**
Cramping = **C**





Since the problem started, it is …. ☐about the same ☐getting better ☐getting worse

Is this condition *interfering* with your: ☐ work ☐sleep ☐daily routine ☐sports/exercise/walking ☐ Leisure ☐ Hobbies ☐Positive Mental Attitude ☐Other ____

It hurts more at the: ☐ beginning of the day ☐ end of the day

It hurts more: ☐ before work ☐ during work ☐ after work

What makes your condition **worse** ?

____

____

What is it like for you when it is **at its worst**?

____

____

What have you done for this condition that is help you feel **better**?

____

____

What have you done for this condition that was **no help**?

____

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

____

____

If your health concerns could be 100% resolved, what would then possible for you? What would you be able to do/be that you are not now able to do/be?

____

____

Are you **unable to do certain activities** that you would like to do because of this pain, illness, or condition? (i.e. sports, walk, pick up grandchildren, etc.) If so, what?

____

____

☐**I do** ☐**do not** have a **family history** of this or similar symptoms. (Please explain)

____

____

Other Doctor's seen for this condition: Chiropractor____ Medical Dr.____ Dentist ____ Other____________________

1. Name/Address: ____

When?_________________________ What did they say was wrong?_______________________________________

What did they do? ____Did it help? __________________________

2. Name/Address: ____

When?____________________________What did they say was wrong?_____________________________________

What did they do? ____Did it help? __________________________

Have you ever had chiropractic care before? Yes____ No____ Date____________________

Name of doctor___________________________ *(Limited Scope/ or Wellness ?)*

How was that experience for you?

____

____

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

1. Type____When__________________Doctor___________________
2. Type____When__________________Doctor___________________
3. Type____When__________________Doctor___________________
4. Type____When__________________Doctor___________________

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

1. Type____When__________________Hospitalized?____Yes _____No
2. Type____When__________________Hospitalized?____Yes _____No
3. Type____When__________________Hospitalized?____Yes _____No

Have you ever had **X-rays** taken? ____________ When? ______________Where?___________________________________

Area of body____

CURRENT MEDICINE(S)

Please list **ALL drugs** you currently take or have taken in the past 6 months.
(The doctor will give you printout from the Physician's Desk Reference with important information.)

Name____Dosage___________For what?_____________

Name____Dosage___________For what?_____________

Name____Dosage___________For what?_____________

Name____Dosage___________For what?_____________

Name____Dosage___________For what?_____________

Name____Dosage___________For what?_____________

Please list all **nutritional supplements, w\vitamins, homeopathic remedies** you presently take:

Name____For what?_______________

Name____For what?_______________

Name____For what?_______________

Name____For what?_______________

Name____For what?_______________

Name____For what?_______________

<u>Please list your top three current stresses in each category:</u>

Physical stress (falls, accidents, work, postures, etc.)

1. ____
2. ____
3. ____

Bio-chemical stress (unhealthy foods, missed meals, don't drink enough water, drugs, alcohol, smoking, etc..)

1. ____
2. ____
3. ____

Psychological stress (work, relationships, finances, self-esteem, etc.)

1. ____
2. ____
3. ____

STRESS LEVELS
Indicate your level of Stress on the number lines below.

NOW	none	0	1	2	3	4	5	6	7	8	9	10	extreme
AVERAGE	none	0	1	2	3	4	5	6	7	8	9	10	extreme

How do you grade your ***Physical*** Health?

Excellent_______Good_______Fair______Poor______ **&** Getting Better______ Getting Worse______ Same______

How do you grade your ***Emotional/Mental*** Health?

Excellent_______Good_______Fair______Poor______ **&** Getting Better______ Getting Worse______ Same______

What Do You Know About Chiropractic?

In your own words, what do chiropractors do?____

____

Do you know what spinal nerve stress/subluxation is? ☐Yes ☐No

If yes, please describe:____

____

Do any of your friends or family see chiropractors? ☐Yes ☐No

If yes, They use chiropractors for: ☐Health maintenance/optimization ☐Health problems ☐Both

Are you seeking chiropractic care for: ☐Health maintenance/optimization ☐Health problems ☐Both

Are you interesting in knowing more about how your nutrition (food you eat) affects your overall health and well-being?

YES _____ NO_____ MAYBE_____

If dietary changes are indicated, would you be willing to make changes in your diet?

YES _____ NO_____ MAYBE_____

Would you take whole food supplements if indicated?

YES _____ NO_____ MAYBE_____

Is there anything else which may help to better understand you which has not been discussed?

____

____

____

Why are you here at this point in time?

____

____

____

Date ____________________________Signature ____