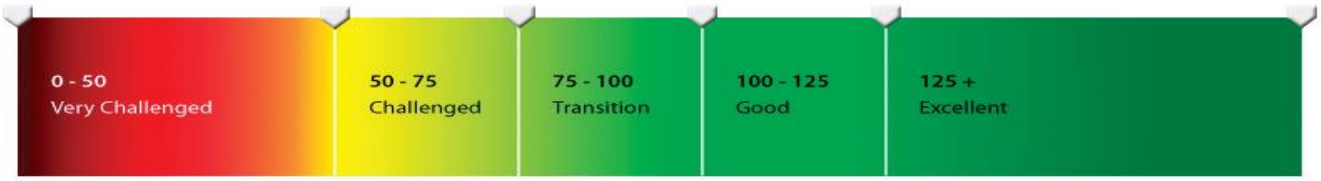
Performance Chiropractic Clinic

Name:_____ email:_____
Address:_____ City:_____ State: _____ Zip:_____
Birthdate: ____/____/____ Age:_____ Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____
Occupation:_____ Work Phone: (_____)_____-_____
Spouse's name:_____ Spouse's phone(emergency contact):_____
Children:_____ age:____; _____ age:_____; _____ age:_____
How did you hear of us?: yellow pages internet Dr. referred patient referral other:_____

YOUR HEALTH:

*As a society we are 50th in the world in health care. We take pride in helping people to reach their optimum health and wellness. With that being said, we need an honest assessment of where you believe your health is and where you would like it to be. So please place an "X" on the scale below marking where you believe your level of health and wellness is at this time. Then place a star (*) on the diagram indicating where you would **like** your health and wellness to be.*



YOUR HEALTH PROFILE:

What brings you into our office? Please briefly describe your chief concern, ***including the impact it has had on your life***. If you have no symptoms or concerns and are here for Chiropractic Wellness Services, please skip to the "General History" part.
Health Concern: Rate Severity: 1-mild 10-severe When did this start? Are symptoms constant or intermittent?

_____
_____
_____
_____
_____
_____

Since the challenge started, it is… ____The Same _____Getting Better _____Getting Worse
What makes it worse? _____
What, if anything makes it feel better? _____
Does this interfere with your: ____Work ____Leisure ____Sleep ____Sports ____Other:_____

It's common for people to have multiple doctors on their health care team. Which of the following have you seen for your health challenges? _____Chiropractor _____Medical Dr. _____ Other Please List:_____
_____

During the above visits, was the cause of your health challenge identified? Yes or No
If Yes what was the diagnosis and recommend solution?_____

Because the Nervous system controls everything in your body, it is common that current health challenges can be related to the problems you are currently seeking care for in our office. Please circle the following symptoms you have had whether current or within the last 6 months.

Headaches	Fatigue	Dizziness	Cold feet
Neck Pain	Depression	Light sensitivity	Diarrhea
Stiff Neck	Sleeping Problems	Memory loss	Acid Reflux
Back Pain	Pins & Needles in legs	Ringing in ears	Constipation
Nervousness	Pins & Needles in arms	Fever	Loss of balance
Tension	Numbness fingers/toes	Loss of taste/smell	Allergies
Irritability	Chest Pains	Cold hands	Fainting

General History

Past Surgeries:

Type:_____ Date:_____
Type:_____ Date:_____
Type:_____ Date:_____

Previous Hospitalizations

_____
_____

Diagnosed Diseases/Conditions/Syndromes:

_____
_____

Medications you currently take:

_____

Family History of Stroke, Diabetes, Heart Disease, High Cholesterol, Hypertension?

_____

It has been shown that daily lifestyle stress significantly impacts your overall health and wellbeing. As a family wellness office we specialize in not only removing the cause of your health challenges, but we also focus on teaching you how to manage the lifestyle stresses that are keeping you from reaching your optimum health and wellness.

Please rate the following and circle **ALL** answers that apply to your habits:
(1 being very poor and 10 being excellent)

Eating habits: _____

a. I eat 3-5x's a day
b. I eat fruits and vegetables daily.
c. I eat out 2-3 times weekly (min)
d. I drink 3-5 sodas weekly
e. I crave sweets.
f. I don't watch what I eat.

Exercise habits:_____

a. I exercise 3-5 times a week.
b. I walk daily.
c. I don't exercise.
d. I want to exercise.
e. I sit at computer 6-8 hours/day

Sleep: _____

a. I sleep 7-9 hours/night
b. I wake up well rested
c. I wake up tired.
d. I toss and turn.
e. I stay up late.

Mind Set: _____

a. I have a positive outlook.
b. I have a negative outlook.
c. I am always in a bad mood.
d. I am always in a good mood.
e. I trap things inside.
f. I share easily.

General Health: ____

a. I am not on medications.
b. I take care of myself.
c. I watch what I eat.
d. I base my health on how everyone around me is doing.
e. I think I am healthy but know I could make some changes.

On a scale of 1-10 describe your psychological/emotional stress levels:
(1= none/ 10=extreme)
Occupational: _____
Personal: _____

YOUR GOALS: At our office we pride ourselves in helping you to achieve phenomenal results with your health and wellness. In order for us to truly help you to be as healthy as possibly, it is important that we understand your goals for your overall health and wellbeing.

Please list your goals for your health and wellness in the spaces provided.

Physical Goals:	Nutritional/ Biochemical Goals	Psychological Goals
(ie.weight, exercise)	**(ie. Off meds, eat better, drink water)**	**(manage stress better, organize)**
_____	_____	_____
_____	_____	_____
_____	_____	_____

If there is a need for dietary changes would you like to know? ☐ Yes ☐ No
If there is a need for specific exercises would you like to know? ☐ Yes ☐ No
If there is a need for support in the psychological/mind/body/stress dimension of health would you like assistance? ☐ Yes ☐ No

You are at the final stretch! The following habits
Have you ever:

Bought bottled water: ☐ Yes ☐ No
Belonged to a health club: ☐ Yes ☐ No
Consumed vitamins or supplements ☐ Yes ☐ No
Eaten organic? ☐ Yes ☐ No
Started a diet program? ☐ Yes ☐ No
Gotten more than 6 massages in a year? ☐ Yes ☐ No

Now we just need your permission to continue through our process!

I consent to a professional and complete chiropractic examination and to any diagnostic testing 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: _____

Doctor Signature_____ Date: _____