Creative Chiropractic

Personal Information

Name: ______________________ Age: __________ Date: __________

Address: ______________________

City / State / Zip: ______________________

Home Phone #: __________ Work Phone #: __________ Cell Phone #: __________

Best Time and # to Call: __________ Email Address: __________

Male: Female: Single: Married: Divorced: Separated: Widowed

Birth Date: ______________________

Occupation: __________ Employer's Name: __________

Spouse's Name: __________ Spouse's Occupation: __________

Names and Ages of Children: ______________________

How did you hear about our office? ______________________

Emergency Contact: __________ Phone #: __________

Your Health Profile

Health Concerns List According to their Severity	Rate of Severity 1 = Mild 10 = Worst Imaginable	When did these problems begin?	Did the problem begin with an injury?	Are the symptoms constant or do they come and go?
1.				
2.				
3.				
4.				

If you are experiencing pain, how would you describe it?

☐ Sharp ☐ Dull Ache ☐ Numbness ☐ Shooting ☐ Cramping ☐ Burning ☐ Stiffness ☐ Throbbing ☐ Swollen

Does the pain travel or radiate anywhere? ☐ No ☐ Yes - Please Describe:

____

These symptoms interfere with my: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation ☐ Family

Since the problem started, it is . . . ☐ About the same ☐ Getting Better ☐ Getting Worse

What makes it worse? ______________________

What makes it better? ______________________

Other Health Professionals seen for this condition: ☐ Chiropractor ☐ Medical Doctor ☐ Other

Name: __________ Date: __________ Diagnosis: __________

What was done? ______________________

Name: __________ Date: __________ Diagnosis: __________

What was done? ______________________

General Health History:

Please Check (X) all symptoms you have ever had, even if they do not seem related to your current health problems:

☐ Headaches
☐ Pins and Needles in arms
☐ Dizziness
☐ Numbness in Fingers
☐ Fatigue
☐ Sleeping Problems
☐ Diarrhea
☐ Cold Sweats
☐ Mood Swings
☐ Dry / Cracked Skin
☐ Pins and Needles in Legs
☐ Loss of smell
☐ Buzzing in ears
☐ Numbness in toes
☐ Depression
☐ Stiff Neck
☐ Constipation
☐ Lights bother eyes
☐ Menstrual Pain
☐ Difficulty Focusing Attention
☐ Fainting
☐ Back Pain
☐ Ringing in Ears
☐ Loss of taste
☐ Irritability
☐ Cold Hands
☐ Fever
☐ Urinary Problems
☐ Menstrual Irregularity
☐ Dry Eyes
☐ Neck Pain
☐ Loss of Balance
☐ Nervousness
☐ Upset Stomach
☐ Tension
☐ Cold Feet
☐ Hot Flashes
☐ Heartburn
☐ Ulcers
☐ Poor Memory

Specific Health History

Birth History-Please check those items that apply to your birth:

__Mother smoked/drank/drugs in pregnancy
__Forceps Delivery
__C-Section Delivery
__Very Short Labor
__Epidural/Meds in labor
__Vacuum Extractor used
__Premature/Overdue
__Very Long Labor
__Breech vaginal Delivery
__Labor Induced
__Complications
__Other____________________

Childhood Years (Age 0-17)-Please check those that apply to you:

__Recurrent Childhood Illness
__Severe Emotional Stress
__Under Chiropractic Care
__Surgery/Stitches
__Vaccinated
__Alcohol/Drug Abuse
__Antibiotics/Other Medications

Adult Years (Age 18-Present)-Please check those items that apply to you:

__Wear Orthotics/Shoe Lifts
__Are you Pregnant? __YES __NO
__Use birth control pills
__Use hormone replacement therapy
__Have been under chiropractic care in the past – How long ago was your last adjustment?___________________

Have you been diagnosed with or suffer from any of the following?

__Diabetes
__High Blood Pressure
__Stroke
__HIV/AIDs
__Cancer
__Asperger Syndrome
__Other
__Systemic Lupus
__Rheumatoid Arthritis
__Psoriatic Arthritis
__Crohn's Disease
__Ulcerative Colitis
__Epilepsy
__Multiple Sclerosis
__Neurofibromatosis
__Muscular Dystrophy
__Cerebral Palsy
__Parkinson's
__Alzheimer's
__Tourette Syndrome
__ADHD / ADD
__Autism

Health History Continued

List all medications that you are currently taking and why: (Prescription and Non-prescription):________________________________

____

Please list all vitamins and supplements that you are currently taking:____

____

Have you ever had surgery?

1. Type:____Date:____________________

2. Type:____Date:____________________

3. Type:____Date:____________________

List any accidents and/or injuries: auto, work related or other (especially those related to your present condition):

1. Type:____Date:______________Hospitalized: ☐ Yes ☐ No

2. Type: ____Date:______________Hospitalized: ☐ Yes ☐ No

3. Type: ____Date:______________Hospitalized: ☐ Yes ☐ No

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

Work Related Stress: __________ Personal Related Stress:____________

On a scale of 1-10 (1 being very poor, 10 being excellent), describe your:

Eating Habits:________Exercise Habits:________Sleep:________General Health:__________

Other Comments or Concerns:____

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____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible. I have read the Privacy Policy of Creative Chiropractic, or I am aware this document is available for my viewing.

Signature:____Date:____________________