# Health Profile

C S W

Date: _______/_______/_______

Name: ____________________________________ Date of Birth: _____/_____/_____ Age: ________ M / F

Address: ___________________________________ City: _________________ State: _____ Zip: ____________

Home Phone: ____________________ Cell: ________________________ Carrier (i.e. AT&T): _______________

Email Address: __________________________________

**How do you prefer to receive reminders? TEXTS / EMAIL / PHONE CALL**

Social Security #__________-______-_________

Occupation: _______________________________ Name of Employer:____________________________________

SINGLE / MARRIED / DIVORCED / WIDOWED Spouse's Name: __________________________________________

Number of Children: _____ Names, Ages & Gender: ___________________________________________________

Do you independently make your own financial decisions for your Health Care? ____ YES ____ NO

Do you have insurance? ____ YES ____ NO Name of Insurance Company: ________________________________

Who may we thank for referring you? _______________________________________________________________

**PLEASE LIST YOUR HEALTH CONCERNS BELOW**

| **Health Concerns?** | **Rate of Severity** 1 = Mild; 10 = Unbearable | **When Did It Begin?** | **How Did It Happen?** | **Did the Problem Begin with an Injury?** | **Are Symptoms Constant, or On and Off?** |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |
| | | | | | |

What health goals would you like to accomplish through chiropractic care?

_____________________________________________________________________________________________

_____________________________________________________________________________________________

If you are experiencing pain, is it: ____ SHARP ____ DULL

Does the pain travel or radiate anywhere? ____ YES ____ NO

If YES, please describe: _________________________________________________________________________

_____________________________________________________________________________________________

Since your problem started, is it: ____ ABOUT THE SAME ____ GETTING BETTER ____ GETTING WORSE

What makes it worse? ___________________________________________________________________________

What makes it better? ___________________________________________________________________________

What other doctors have you seen for this condition? ____ CHIROPRACTOR ____ MEDICAL DOCTOR ____ OTHER

List surgical operations and years: ________________________________________________________________

____________________________________________________________________________________________

List all medications you are on: ___________________________________________________________________

____________________________________________________________________________________________

When was your last auto accident? _________________________________________________________________

Have you had previous chiropractic care? ____ YES ____ NO

If YES, list most recent date and doctor's name: ______________________________________________________

Have you ever been unconscious? ____ YES ____ NO Have you ever fractured a bone? ____ YES ____ NO

If YES to either, please describe: ____________________________________________________________________

____________________________________________________________________________________________

Have you had any other bodily trauma? _______________________________________________________________

**PLEASE CIRCLE ANY CONDITIONS YOU HAVE NOW OR HAVE HAD IN THE PAST:**

Stroke Cancer Heart Disease Spinal Surgery Seizures Spinal Bone Fracture Scoliosis Diabetes

**PLEASE CIRCLE ANY AND ALL ISSUES YOU HAVE HAD WITHIN THE LAST TWO YEARS:**

| | | | |
|---|---|---|---|
| Asthma | Arthritis | TMJ | Chronic Fatigue |
| Epilepsy | Gastric Reflux | Heart Disorders | Lupus |
| Ulcers | Sciatica | Irritable Bowel | Nausea |
| Dizziness | Numbness in Arms | Disc Problems | Menstrual Disorder |
| Kidney Problems | Numbness in Legs | Liver Disease | Neck Pain |
| Headaches | Numbness in Hands | Low Back Pain | Migraines |
| Vertigo | Numbness in Feet | Mid Back Pain | Stiffness in Neck |
| Chest Pains | Ear Infections | Stomach Disorder | Hip Pain |
| Arm Pains | Grating in Neck | Leg Pain | Anxiety |
| Nervousness | Shoulder Pain | Fainting | Chronic Sinus |

Other: ______________________________________________________________________________________

**LIST SYMPTOMS/COMPLAINTS IN ORDER OF MOST DISCOMFORT:**

1. ______________________________ 4. ______________________________

2. ______________________________ 5. ______________________________

3. ______________________________ 6. ______________________________

NEW LIFE CHIROPRACTIC

# Family Health History Profile

This form is to assist the doctors of New Life Chiropractic by providing past family health history information for their review.

| Condition | Spouse | Son | Daughter | Mother | Father |
|---|---|---|---|---|---|
| Arm Pain | | | | | |
| Arthritis | | | | | |
| Asthma | | | | | |
| ADD/ADHD | | | | | |
| Allergies | | | | | |
| Back Trouble | | | | | |
| Bed Wetting | | | | | |
| Cancer | | | | | |
| Carpal Tunnel | | | | | |
| Deceased | | | | | |
| Diabetes | | | | | |
| Digestive Problems | | | | | |
| Disc Problems | | | | | |
| Ear Infections | | | | | |
| Fibromyalgia | | | | | |
| Headaches | | | | | |
| Heartburn | | | | | |
| High Blood Pressure | | | | | |
| Hip Pain | | | | | |
| Leg Pain | | | | | |
| Menstrual Disorder | | | | | |
| Migraines | | | | | |
| Neck Pain | | | | | |
| Scoliosis | | | | | |
| Shoulder Pain | | | | | |
| Sinus trouble | | | | | |
| TMJ | | | | | |

# Informed Consent for Chiropractic Care

Chiropractic care, like all forms of health care, offers considerable benefits. However, it may also provide some level of risk. Risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications which have been reported secondary to chiropractic care include: sprain/strain injuries, irritation of disc condition, and, rarely, fractures. One of the rarest complications associated with chiropractic care occurs at a rate between one instance per one million to one per two million vertebral spine (neck) adjustments, and may be a vertebral injury leading to stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination must be completed. These procedures are performed to assess your specific conditions, your overall health, and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning your care.

## THE NATURE AND PURPOSE OF CHIROPRACTIC

Adjustments are made by chiropractors in order to correct spinal and extremity joint subluxations. One of the most common disturbances to the nerve system is the vertebral subluxation. This condition is where one or more vertebrae in the spine are misaligned sufficiently enough to cause interference and/or irritation to the nerve system. The primary goal in chiropractic health care is to remove nerve interference caused by subluxation. A chiropractic adjustment is the application of a precise, high velocity movement of the spine over a very short distance. There are a number of different methods or techniques by which a chiropractic adjustment is delivered. Adjustments at New Life Chiropractic are typically delivered via a gentle instrument or in some cases, by hand.

## CONSENT FOR CHIROPRACTIC CARE

Signing below indicates I understand and accept the risks associated with chiropractic care and give consent to the examination the doctor deems necessary, along with the recommended chiropractic care, including spinal adjustments, as reported following my assessment.

| ______________________________ | ____________ | ______________________________ |
|---|---|---|
| Patient Signature | Date | Witness Signature |