MEADOWS FAMILY CHIROPRACTIC

Name____DOB___/___/___Age_____Today's Date___/___/___
Address ________________________________ City___________________ State______ Zip_____________
SSN:_____-____-______ Driver's License #_____________________ Sex: *Male* *Female* (circle one)
Home #(   )___________________Page/Cell #(   )__________________Work #(   )________________
Email____Occupation_______________________________
Employer's Name ____
Address: ________________________________ *City*________________ *State*_______ *Zip*:__________
Single *Married* *Divorced* *Widowed* Name of Spouse ____________________________
# of children_______ Names of children____
Who can we thank for referring you to our office? ____

Was this injury a result of: ☐ Work Injury? ☐ Car Accident? ☐ Other Injury? (check one)

YOUR HEALTH PROFILE

WHY THIS FORM IS IMPORTANT: As a chiropractic office that centers on family wellness, we focus on helping you reach your optimum health potential. Our first goal is to locate and eliminate any and all interference to reaching your maximum potential while addressing the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a lifetime of health, happiness and vitality. We all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes when it's already too late! Your answers to the following questions will give us a general view of the stresses you have faced in your life. This will allow us to better assess your current status and more accurately determine your true health potential.

THE BEGINNING YEARS – Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

BIRTH HISTORY – *Please check all that apply.*

☐ Mother smoked/drank/drugs during pregnancy ☐ Epidural/Med's in Labor ☐ Breech
☐ C-Section ☐ Forceps Delivery ☐ Vacuum Extractor Used ☐ Labor Induced
☐ Complications ☐ Other ____

CHILDHOOD YEARS (0-17 years) – *Please check all that apply.*

☐ Childhood illness ☐ Serious Falls ☐ Active in sports ☐ Very Inactive
☐ Car Accident(s) ☐ Surgery/Stitches ☐ Alcohol Abuse ☐ Smoker
☐ Antibiotics ☐ Drug Abuse ☐ OTC Medications ☐ Vaccinated
☐ Broken Bones ☐ Under Chiropractic Care ☐ Severe Emotional Trauma(s)_______________________

ADULT YEARS (Age 18 to Present) – *Please check all that apply.*

☐ Present Smoker ☐ Former Smoker ☐ OTC Medications ☐ Poor sleep
☐ Alcohol Use ☐ Play Sports ☐ Surgery/Stitches: yrs old? ______ ☐ Work Injury
☐ High Job Stress ☐ High Personal Stress ☐ Poor Diet ☐ Drive a lot
☐ Flat feet ☐ Prescription Medications ☐ Not Enough Sleep ☐ Broken Bones
☐ No Exercises ☐ Severe Health Problems ☐ Wear Orthotics/Lifts ☐ Sit a lot
☐ Car Accidents: ______________________ (yrs old?) ☐ *Other Injuries*:
____
☐ Have been under chiropractic care in the past – How long ago was your last adjustment?___________________

Please list all prescriptions you are currently taking: ____

ISSUES THAT BROUGHT YOU TO OUR OFFICE

**If you have no symptoms or complaints and you are here for wellness care please check the box below.
☐ **WISH TO HAVE WELLNESS SERVICES** (Skip to FAMILY HEALTH PROFILE at the bottom of this form.)

CHIEF COMPLAINT(S) ____

____

How has this affected your life?____

____

If you have pain, is it… ☐ Mild ☐ Moderate ☐ Severe ☐ Intolerable
☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent ☐ Traveling ☐ Radiating

Since it began, is it… ☐ About the same ☐ Variable ☐ Getting better ☐ Getting worse
What makes it worse?____
What has made it better in the past but stopped working?____
What makes it better?____

Does it interfere with… ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Exercise
☐ Hobbies ☐ Leisure activity ☐ Other ____

Did you have an injury? ☐ Yes ☐ No *If yes, please explain* ____________________________

How long have you had this problem? ____
Have you had similar problems in the past?____
Is there a time of day that is worse typically? ☐ Yes ☐ No If Yes, when? ____________________________

Other doctors/treatments you've tried for this problem (Please list):
☐ Chiropractor____
☐ Medical Doctor *(their names)*____
☐ Other ____

PLEASE CHECK ALL RECURRING OR SEVERE SYMPTOMS YOU HAVE EVER HAD, EVEN IF THEY SEEM UNRELATED TO YOUR CURRENT PROBLEM:

☐ Headaches/Migraines
☐ Infertility/Impotence/Miscarriage
☐ Back stiffness/pain
☐ Buzzing/ringing in ears
☐ Numbness in fingers
☐ Stomach Upset
☐ Tension/Stress
☐ Neck stiffness/pain
☐ Diarrhea/Constipation/Gas
☐ Hot Flashes
☐ Problems urinating
☐ Pre-Menstrual Syndrome
☐ Jaw/TMJ Problems
☐ Pins & Needles in legs/feet
☐ Pins & Needles in arms
☐ Loss of balance
☐ Sinus Problems/Issues
☐ Numbness in toes
☐ Fatigue
☐ Irritability/Mood Swings
☐ Cold hands
☐ Foot Problems
☐ Cold Sweats
☐ Heartburn/Acid reflux
☐ Menopause
☐ Other: ____
☐ Recurring Infection
☐ Loss of Smell
☐ Dizziness/vertigo
☐ Nervousness/Anxiety
☐ Loss of taste
☐ Depression
☐ Sleeping Problems
☐ Cold feet
☐ Shortness of breath
☐ Light bothers eyes
☐ High Blood Pressure
☐ Ulcers

FAMILY HEALTH PROFILE – In our office, we are not only interested in your health & well being, but also that of your family and loved ones. Please mention any health conditions or concerns you may have about your:

CHILDREN______________________________ SIBLINGS ______________________________
SPOUSE ______________________________ OTHER ______________________________
PARENTS ____

Current exercises: ____________________ # days per week: _____ **Current supplements** (*list*): ____________________

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. If the office accepts an assignment of benefits under any insurance plan, the Patient will remain primarily responsible for all bills and shall be obligated to pay any and all sums not actually paid by the insurance carrier. I agree to allow this office to examine me for further evaluation.

____ _____/_____/_______
Signature Date

Please list your pains / complaints from MOST to LEAST severe & fill out column for each complaint

	MOST	>	>	LEAST
	Complaint #1	Complaint #2	Complaint #3	Complaint #4
Today, you have the following physical complaints:	____________ ____________ ____________	____________ ____________ ____________	____________ ____________ ____________	____________ ____________ ____________
Is this complaint: Sharp, Dull, Achy, Throbbing, Numb, Shooting, or Other? (explain)	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Electric/Shooting	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Electric/Shooting	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Electric/Shooting	☐ Sharp ☐ Dull ☐ Achy ☐ Throbbing ☐ Numb ☐ Electric/Shooting
How often do you feel this complaint? Constant, Daily, Off & On, Weekly?	☐ Constant ☐ Daily ☐ Off & On ☐ Weekly ☐ Monthly ☐ Other________	☐ Constant ☐ Daily ☐ Off & On ☐ Weekly ☐ Monthly ☐ Other________	☐ Constant ☐ Daily ☐ Off & On ☐ Weekly ☐ Monthly ☐ Other________	☐ Constant ☐ Daily ☐ Off & On ☐ Weekly ☐ Monthly ☐ Other________
How long have you had this?	____________ ____________ ____________	____________ ____________ ____________	____________ ____________ ____________	____________ ____________ ____________
Is it getting better, worse, or staying the same?	☐ Better ☐ Worse ☐ Same	☐ Better ☐ Worse ☐ Same	☐ Better ☐ Worse ☐ Same	☐ Better ☐ Worse ☐ Same
What makes it better?	____________ ____________ ____________	____________ ____________ ____________	____________ ____________ ____________	____________ ____________ ____________
What makes it worse?	____________ ____________ ____________	____________ ____________ ____________	____________ ____________ ____________	____________ ____________ ____________
On a scale of 1-10 Rate your discomfort:	Circle one 10 9 8 7 6 5 4 3 2 1 0 10 = Excruciating 0 = No Discomfort	Circle one 10 9 8 7 6 5 4 3 2 1 0 10 = Excruciating 0 = No Discomfort	Circle one 10 9 8 7 6 5 4 3 2 1 0 10 = Excruciating 0 = No Discomfort	Circle one 10 9 8 7 6 5 4 3 2 1 0 10 = Excruciating 0 = No Discomfort
How have you taken care of this in the past? How has it worked for you?	____________ ____________ ____________	____________ ____________ ____________	____________ ____________ ____________	____________ ____________ ____________
This issue is affecting my:	☐ Job ☐ Childcare ☐ Marriage ☐ Sex ☐ Exercise ☐ Finance ☐ Playing with kids ☐ Bowels ☐ Urine	☐ Job ☐ Childcare ☐ Marriage ☐ Sex ☐ Exercise ☐ Finance ☐ Playing with kids ☐ Bowels ☐ Urine	☐ Job ☐ Childcare ☐ Marriage ☐ Sex ☐ Exercise ☐ Finance ☐ Playing with kids ☐ Bowels ☐ Urine	☐ Job ☐ Childcare ☐ Marriage ☐ Sex ☐ Exercise ☐ Finance ☐ Playing with kids ☐ Bowels ☐ Urine
Helping this issue would increase my quality of life by:	☐ 10-20% ☐ 30-40% ☐ 50-60% ☐ 70-80% ☐ 90% ☐ 100%	☐ 10-20% ☐ 30-40% ☐ 50-60% ☐ 70-80% ☐ 90% ☐ 100%	☐ 10-20% ☐ 30-40% ☐ 50-60% ☐ 70-80% ☐ 90% ☐ 100%	☐ 10-20% ☐ 30-40% ☐ 50-60% ☐ 70-80% ☐ 90% ☐ 100%

Over 70% of our patients bring their children in to get adjusted. If you would like to have your children and/or spouse checked for subluxations check the box below and they can receive a complimentary exam including any necessary X-rays within 2 weeks of you starting care. The exam is of no cost to you and does not obligate them to receive future care. Has your spouse complained of back, neck, or shoulder pain in the last 3 years? Bring them in for a free check.

☐ Yes, I would like my family members checked for subluxations in the next 2 weeks.

Print NAME:______________________________ **DATE:**______________