Today's Date: _____

Dear Practice Member,

We are so honored to serve you today. Please begin by completing this questionnaire. Your answers will help us determine if chiropractic can help you. **We only accept those Practice Members that we can help and that want to be helped!** Thank You.

Name _____ Age _____ Birth Date _____

Address _____ City _____ ST _____ Zip _____

Phone # (H)_____ (O) _____ Email _____

Sex M. / F. Social Security # ____-___-_____ Occupation _____

Marital Status _____ Spouse Name _____

Of Children _____ Names _____

Were you referred to this office? Y / N (if yes, by whom?) _____

Cell:_____

YOUR HEALTH PROFILE

Research demonstrates that many of the health challenges that occur in life have their origins during the developmental years, some as early as birth. Please answer the following questions to the best of your ability.

CHILDHOOD YEARS (0-18 years) and severity.	**NO**	**YES**	**If yes, please give dates**
Did you have any childhood illnesses?	☐	☐	_____
Did you have any serious falls as a child?	☐	☐	_____
Did you take/use any drugs?	☐	☐	_____
Did you have any surgery?	☐	☐	_____
Did you fall/jump from a height over 3 feet?	☐	☐	_____
Were you involved in any car accidents?	☐	☐	_____
Was there any prolonged use of medicines? (I.e. antibiotics, inhaler)	☐	☐	_____
Did you suffer any trauma? (Physical/emotional)	☐	☐	_____
Were you vaccinated?	☐	☐	_____
Did you receive regular Chiropractic care?	☐	☐	_____

ADULT YEARS– (18 to present)			
Do / did you smoke?	☐	☐	_____
Do / did you drink alcohol?	☐	☐	_____
Have you been in any accidents?	☐	☐	_____
Have you had any surgery?	☐	☐	_____
Did / do you play sports?	☐	☐	_____

On a scale of 1 – 10 rate your stress level

(1= none / 10 = extreme)

Occupational _____Personal _____

On a scale of *Poor, Good, Excellent* describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____