Wills Chiropractic

Adult Health Profile

Why This Form Is Important

As a wellness center, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical, and psychological stresses that can accumulate and result in serious loss of health potential. Answering the following questions will give us a profile of the specific stresses that you face and allow us to better assess the challenges to your health potential and the functioning of your nervous system, which is the essence of chiropractic.

Reason for visit: ☐ Wellness ☐ Chiropractic ☐ Massage ☐ Power Plate ☐ Other ________________ Date __________

DEMOGRAPHICS

First Name ______________________ Middle Name ___________________ Last Name _____________________

Nickname ______________________ SSN ____________________ Date of Birth _____________ ☐ Male ☐ Female

Street Address ____ City / State / Zip _______________________

Email Address ____

Home Phone ______________ ☐ Primary ☐ Secondary Cell Phone ________________ ☐ Primary ☐ Secondary Alternate Phone ______________ ☐ Primary ☐ Secondary

MARITAL / DEPENDENT STATUS

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name _________________________

Number of Dependents _____ Dependents Name(s)/Age(s)____

APPOINTMENT REMINDERS

If you would like an appointment reminder sent via text message please complete the following:

Service Provider (ie: Verizon/AT&T, etc.) _____________________ Cellular Number _____________________________

How far in advance would you like your text message reminder: ☐ 15 minutes ☐ 30 minutes ☐ 45 minutes ☐ 1 hour ☐ 2 hours ☐ 4 hours

EMPLOYMENT

Employer ____ Job Title ____________________________________

Employers Address ____ Employers Phone ________________

EMERGENCY CONTACT

Emergency Contact ___________________________ Relationship _____________ Telephone ________________

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CURRENT CONDITION(S)

Primary Concern ____ Date Episode Began ____________

Condition Came On: ☐ Gradually ☐ Immediately ☐ Pre-Existing; Began ____________

Condition is: ☐ Getting Better ☐ Getting Worse ☐ Staying Same

Describe Feeling: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing

☐ Burning ☐ Numbing ☐ Tingling ☐ Other____________________

Did condition begin with a specific injury/incident? ☐ Yes ☐ No If yes, please describe: __________________

____

____

Have you seen a Doctor for this condition? ☐ Chiropractor ☐ Medical ☐ Other _________________________

Secondary Concern ____ Date Episode Began ____________

Condition Came On: ☐ Gradually ☐ Immediately ☐ Pre-Existing; Began ____________

Condition is: ☐ Getting Better ☐ Getting Worse ☐ Staying Same

Describe Feeling: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing

☐ Burning ☐ Numbing ☐ Tingling ☐ Other____________________

Did condition begin with a specific injury/incident? ☐ Yes ☐ No If yes, please describe: __________________

____

____

Have you seen a Doctor for this condition? ☐ Chiropractor ☐ Medical ☐ Other _________________________

Additional Concern(s) ____ Date Episode Began ____________

Condition Came On: ☐ Gradually ☐ Immediately ☐ Pre-Existing; Began ____________

Condition is: ☐ Getting Better ☐ Getting Worse ☐ Staying Same

Describe Feeling: ☐ Dull ☐ Sharp ☐ Aching ☐ Shooting ☐ Spasm ☐ Throbbing

☐ Burning ☐ Numbing ☐ Tingling ☐ Other____________________

Did condition begin with a specific injury/incident? ☐ Yes ☐ No If yes, please describe: __________________

____

____

Have you seen a Doctor for this condition? ☐ Chiropractor ☐ Medical ☐ Other _________________________

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SKILL DIFFICULTY

Please indicate current skills which are difficult to perform due to concerns on the previous page:

☐ Seeing	☐ Kneeling	☐ Holding	☐ Climbing	☐ Insomnia
☐ Reading	☐ Squatting	☐ Carrying	☐ Walking	☐ Loss of concentration
☐ Hearing	☐ Sitting	☐ Pulling	☐ Sports	☐ Other ____________
☐ Tasting	☐ Reclining	☐ Pushing	☐ Exercising	
☐ Eating	☐ Standing	☐ Reaching	☐ Driving	
☐ Smelling	☐ Leaning	☐ Pinching	☐ Riding in car	
☐ Grooming	☐ Bending	☐ Grasping	☐ Using the toilet	
☐ Dressing	☐ Twisting	☐ Writing	☐ Tactile feeling	
☐ Bathing	☐ Lifting	☐ Typing	☐ Restful Sleeping	

PREVIOUS SYMPTOMS

Please indicate any symptoms experienced in the past six (6) months.

☐ Pins & needles in arms	☐ Headaches	☐ Chronic cough	☐ Diarrhea
☐ Pins & needles in legs	☐ Fainting	☐ Fatigue	☐ Constipation
☐ Numbness in fingers	☐ Seizures	☐ Sleeping problems	☐ Stomach upset
☐ Numbness in toes	☐ Ringing in ears	☐ Nervousness	☐ Heartburn
☐ Cold hands	☐ Buzzing in ears	☐ Depression	☐ Ulcers
☐ Cold feet	☐ Ear infections	☐ Irritability	☐ Urinary problems
☐ Neck pain/stiffness	☐ Lights sensitivity	☐ Tension	☐ Incontinence
☐ Back pain/stiffness	☐ Cold sweats	☐ Mood swings	☐ Loss of smell
☐ Loss of balance	☐ Hot flashes	☐ Menstrual pain	☐ Loss of taste
☐ Dizziness	☐ Fever	☐ Menstrual irregularity	☐ Other __________________

ALLERGIES

☐ Environmental	☐ Non-Contributory	☐ Seafood
☐ Food reactions	☐ Penicillin	☐ Sulfa
☐ No known allergies	☐ Pets	☐ Other __________________

PAST MEDICAL HISTORY

☐ ADHD	☐ Depression	☐ High Blood Pressure	☐ Stomach Ulcers
☐ Allergies	☐ Diabetes	☐ High Cholesterol	☐ Stroke
☐ Asthma	☐ Heart Attack	☐ Osteoarthritis	☐ Thyroid Disease
☐ Cancer	☐ Heart Disease	☐ Renal Disease	☐ Other _____

PAST SURGICAL HISTORY

Surgical Procedure ____ Surgery Date _____________

Surgical Procedure ____ Surgery Date _____________

Surgical Procedure ____ Surgery Date _____________

Surgical Procedure ____ Surgery Date _____________

ADDITIONAL CONCERNS

Please list any additional concerns you would like to address with the doctor: ______________________________

____

____

____

ACCIDENT AND/OR INJURY HISTORY

Please indicate any injuries which were/are the result of auto, work or sports related injuries: ________________

____

____

____

FAMILY HISTORY

Please select and indicate family member(s) affected by the conditions below (ie: Mother / Father / Sister / Brother / Grandparent):

☐ Allergies __________________________________

☐ Asthma ___________________________________

☐ Cancer ____________________________________

☐ Depression ________________________________

☐ Diabetes __________________________________

☐ Heart Attack _______________________________

☐ Heart Disease ______________________________

☐ High Blood Pressure ________________________

☐ High Cholesterol ___________________________

☐ Osteoarthritis ______________________________

☐ Renal Disease ______________________________

☐ Stomach Ulcers _____________________________

☐ Stroke _____________________________________

☐ Thyroid Disease ____________________________

MEDICATIONS AND LIFESTYLE

Please list medications and/or nutritional supplements currently being taken and the reason for taking them: ____

____

____

Please list any unhealthy lifestyle habits (ie. tobacco, alcohol, caffeine, junk food): ________________________

____

Do you wear orthotic shoe inserts? ☐ Yes ☐ No How long have you worn your foot orthotics? ____________

Have you had chiropractic care in the past? ☐ Yes ☐ No If yes, when was your last adjustment? ___________

Were you satisfied with your previous care? ☐ Yes ☐ No If no, please explain __________________________

____

How did you hear about our office? ____

Who may we thank for referring you to our office? ____

CONSENT AND AUTHORIZATION

Please read and initial each paragraph below. If you have questions regarding your consent and authorization, please ask a Wills Chiropractic staff member for assistance.

______ I consent to a professional and complete chiropractic examination and to any radiographic examination 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.

______ I understand I am financially responsible, whether or not my insurance company pays, for all charges incurred by me. I hereby assign my major medical insurance benefits, private insurance and other health plans (excluding Medicare) to Wills Chiropractic. Any overpayment will be refunded.

______ I authorize Wills Chiropractic to release any medical information and/or x-rays as needed to process claims for services rendered. I understand that this release is revocable at any time prior to the release of this information.

I have read, I understand, and I agree to comply with the above.

Patient Name ______________________________________

Signature ____ Date ______________