

Wills Chiropractic

Health Profile

Today's Date: _____

Name: _____

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.

Name: _____ SSN: _____ Birth Date: _____

Nickname: _____ Male Female Age: _____

Dominance: Right Handed Left Handed Ambidextrous

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

City / State / Zip: _____

Email Address: _____

Occupation: _____ Employers Name and Address: _____

Single Married Divorced Widowed Spouse's Name: _____

Number of Children: _____ Names and Ages: _____

Emergency Contact: _____ **Phone:** _____

Relationship to you: _____

Who may we thank for referring you to our office/how did you hear about us? _____

Complaint 1: _____

Came On: Gradually **It Is Getting:** Better

Immediately Same

Worse

When did this episode start? _____ If you had the condition before, when? _____

How did it happen? _____

Did problem begin with an injury? _____

Describe Feeling: Dull Sharp Aching Shooting Spasm

Throbbing Burning Numbing Tingling Other _____

Have you seen other Doctors for this condition? Chiropractor Medical Dr. Other _____

Please mark (X) all symptoms you have experienced in the past four (4) months, even if they do not seem related to your current problem:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Back pain | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Buzzing in ears | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Stiff neck | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Ulcers |

Accidents and/or injuries: auto, work related, or other (especially those related to your present problems).

Past Medical History:

- | | | | | |
|--|--|---|--|---------------------------------|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Heart Attack | | |
| <input type="checkbox"/> Other _____ | | | | |

Past Surgical History:

Past Surgical History 1: _____

Past Surgical History 2: _____

Past Surgical History 3: _____

Past Surgical History 4: _____

Past Surgical History 5: _____

Allergies:

- | | |
|---|--|
| <input type="checkbox"/> No known drug/ environmental/ food allergies | <input type="checkbox"/> Environmental allergies |
| <input type="checkbox"/> Food reactions | <input type="checkbox"/> Non-Contributory |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Pets |
| <input type="checkbox"/> Seafood | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Other _____ | |

Past Family History: (Please check mark the appropriate box and indicate the family member)

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

Please list any medications and/or nutritional supplements (i.e. vitamins, calcium, herbs) that you currently take and why: _____

Please list your unhealthy lifestyle habits (ie. tobacco, alcohol, coffee, junk food): _____

Have you ever seen a chiropractor? _____ If yes, what was your experience like? _____

Do you wear orthotics/shoe inserts for your feet? YES or NO How old are they? _____

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 promptly refunded. I also authorize Wills Chiropractic to release any information needed to secure payment. If my balance becomes delinquent and suit is filed, I agree to pay all collection costs including attorney fees and court costs. I read, understand, and agree to comply with the above.

Signature _____ **Date:** _____

AUTHORIZATION FOR CARE OF MINOR

I hereby authorize this office and its Doctors to administer care to my Son/Daughter as they deem necessary. I clearly understand and agree that I am personally responsible for payment of all fees charged by this office.

Name of Insurance Company: _____ **Policy #:** _____

Signed: _____ **Date:** _____