

Your Wellness History – Health Profile

Name: _____ DOB: _____ Date: _____

Age: _____ M / F Status: Single Married Partnered Divorced Widowed Spouse: _____

Address: _____ City/State: _____ ZIP: _____

Phone: Home: _____ Cell: _____ Work: _____

E-mail: _____ Best time to contact: _____

of Children: _____ Names/Ages: _____

Occupation: _____ Employer: _____

Referred by: _____ Relationship: _____

Rate your health and wellness

Place an **'X'** on the scale where you see your current level of wellness.

Place an **'O'** on the scale where you would like your wellness to be.



YOUR HEALTH PROFILE

- What brings you into our office today?

Please briefly describe any current complaints, including the impact it (they) has (have) had on your life. If you're only here for chiropractic wellness services please skip this part and go to "General History" on the next page.

Rate severity (scale 1-10, 1 being mild)

When and how did this start?

Are symptoms constant or intermittent?

- Since the problem started it is: _____ the same _____ getting better _____ getting worse

What makes the problem worse? _____

What, if anything, makes the problem feel better? _____

- Does this interfere with your: _____ Leisure _____ Work _____ Sleep _____ Sports _____ Other

Have you seen other doctors for this condition? _____ Chiropractor _____ MD _____ Other

Name/Address: _____ Date: _____

What was the diagnosis: _____

GENERAL HISTORY

- Please list all medications (prescription and OTC) you are taking, and why. Use back of pg. 3 if needed.

- Have you had any surgeries and/or hospitalizations? ___ Yes ___ No

If yes, briefly explain: _____

- Have you ever had any work related injuries? ___ Yes ___ No

If yes, briefly explain: _____

- Have you ever had any slips, falls, or auto accidents? ___ Yes ___ No

If yes, briefly explain: _____

Please check all symptoms (now or in the past) you have ever had, even if they do not seem related to your current problem.

Current	Past		Current	Past	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Pins & needles in arms	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands
<input type="checkbox"/>	<input type="checkbox"/>	Pins & needles in legs	<input type="checkbox"/>	<input type="checkbox"/>	Cold feet
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Fever
<input type="checkbox"/>	<input type="checkbox"/>	Numbness in fingers	<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping problems	<input type="checkbox"/>	<input type="checkbox"/>	Eyes bothered by light
<input type="checkbox"/>	<input type="checkbox"/>	Tension	<input type="checkbox"/>	<input type="checkbox"/>	Stomach upset
<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Buzzing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Cold sweats
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	<input type="checkbox"/>	Numbness in toes	<input type="checkbox"/>	<input type="checkbox"/>	Loss of smell
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Loss of taste
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Back pain
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual pain	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual irregularity	<input type="checkbox"/>	<input type="checkbox"/>	Stiff neck

YOUR GOALS

- On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/psychological/lifestyle stress levels:

Scale = _____ Occupational Stress: _____

Scale = _____ Personal Stress: _____

- On a scale of 1 to 10 (1 = poor, 10 = excellent), describe your habits and conditions as related to:

Eating _____ Exercise _____ Sleep _____ General Health _____ Wellness Lifestyle _____

Please check all that are relevant to you:

Do you:

- Drink ½ your body weight in ounces of water
- Exercise Regularly
- Take vitamins or supplements

Would you like to know more about:

- Proper nutrition and meal planning
- Proper exercise routines and techniques
- How to deal with lifestyle stress

**Thank you for taking time to tell us about you!
It is your first step to Creating Wellness in your life!**

By my signature below I hereby consent to a professional and complete chiropractic examination, and to any radiographic examination that the doctor deems necessary. I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date unless prior arrangements have been made between me and McCarley Chiropractic: A Creating Wellness Center.

Signature: _____ Date: _____

Please return this form to our staff and someone will be right with you.