



Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ Age: _____ Male Female Height: _____ Weight: _____

Home #: _____ Work #: _____ Cell #: _____

Best time to contact: _____ How did you hear about us? _____

Email address: _____ Status: Single Married Divorced Widowed

Number of Children: _____ Names/Ages: _____

Occupation: _____ Employer Name/Phone: _____

Your Health Profile

What brings you into our office today? Please briefly describe any health symptoms, including the impact it has had on your life. Please rate the severity (scale 1-10, 1 being mild). Also include 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 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 Health

Please list all medications and supplements you are taking, and why. (Prescription and non-prescription) _____

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 you have currently (C) or have had in the past (P), even if they do not seem related to your current problem. You may write notes to explain, if desired.

(C) (P)

- Headaches
- Pins & needles in arms
- Pins & needles in legs
- Sleeping problems
- Tension
- Acid reflux or ulcers
- Buzzing in ears
- Ringing in ears
- Numbness in toes
- Depression
- Constipation
- Menstrual pain
- Menstrual irregularity
- Hot flashes
- Irritability
- Cold hands
- Cold feet

(C) (P)

- Fever
- Dizziness
- Numbness in fingers
- Fatigue
- Urinary problem
- Fainting
- Eyes bothered by light
- Stomach problems
- Diarrhea
- Cold sweats
- Mood Swings
- Loss of smell
- Loss of taste
- Back pain
- Neck Pain
- Stiff neck
- Digestive problems:

Current Lifestyle

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

Scale = ___ Occupational stress: _____

Scale = ___ Personal stress: _____

Please indicate what you consume in a typical day:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Beverages: _____

Habits (please check all that apply):

Alcohol

Laxatives

Chocolate

Tea

Sugar

Sugar Substitute

Cigarettes

Coffee

Do you consider yourself: Overweight Average Underweight

Describe activity level: Sedentary Light Moderate Heavy

How many meals do you typically eat out in a week? ____ How many glasses of water do you drink daily? ____

List any foods you crave: _____

List any foods you avoid (for any reason): _____

At our office we're concerned about your health and wellness goals. Please take a moment to list your goals in the following categories:

Be Fit. (Physical)

Eat Right. (Nutritional)

Think Well. (Psychological)

I 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.

Signature: _____ Date: _____

If you filled this form out at home, you may print it and bring it with you to your first appointment or email it to us at office@totalbalancechiro.com. Otherwise please return this form to the front desk and someone will be right with you.