Personal Health Profile

Name: ________________________________ Referred By:_________________________

Address: _______________________________________ City: ______________________

Postal Code: _____________ Age: ______ Birthdate: (D)_____/ (M)_____/ (Y) _______

Home Tel: ________________

Mother's Name: _____________________ Father's name _____________________________

Email: ____

ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system, that have resulted in poor health. Following your exam, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Loss of Whole Body Health (Birth to Present)

From birth, certain stresses in your life start to produce layers of damage to your spine and nervous system. Eventually you begin to experience symptoms and random bouts of sickness.

Childhood History

Childhood Surgeries:____

Childhood injuries, falls, car accidents:____

Contact Sports:____

Concussions: □No □Unsure □Yes When/How many____

YOUR CHILD'S HISTORY:

1. As a baby / toddler, **(birth to 4 years)**, did any of the following occur?

- ☐ Fall from a change table
- ☐ Tumble down stairs
- ☐ Fall out crib
- ☐ Play in "Jolly Jumper"
- ☐ Fall off playground equipment
- ☐ Slow weight gain
- ☐ Frequent crying spells
- ☐ Frequent fevers
- ☐ Colic
- ☐ Involved in car accident
- ☐ Reaction to vaccination
- ☐ Tonsilitis
- ☐ Other

Please explain 'other':____

____

____

2. As a young child, **(5-13 years),** did any of the following occur?

- ☐ Fall from a tree
- ☐ Bed wetting
- ☐ Stomach pains
- ☐ Fall off a bicycle
- ☐ Hyperactivity / Autism
- ☐ Scoliosis
- ☐ Fall off playground equipment
- ☐ Learning difficulties
- ☐ Allergies
- ☐ Sports accident
- ☐ Asthma
- ☐ Leg / knee pains
- ☐ Involved in car accident
- ☐ Other: ________________________________

Please explain 'other':____

____

____

3. Vaccinations received? ____

____

____

Any reactions? ____

Many times symptoms indicate a long standing spinal condition. Please check off any symptoms you experience now, or have experienced in the past.

Cervical

Past	Present	
□	□	Headaches
□	□	Migraines
□	□	Fatigue
□	□	Insomnia
□	□	Problems during sleep
□	□	Irritability
□	□	Anxiety
□	□	Depression
□	□	Neck Pain
□	□	Dizziness
□	□	Nausea
□	□	Loss of Concentration
□	□	Arm pain/numbness □ Left □ Right
□	□	Hand pain/numbness □ Left □ Right
□	□	Thyroid Issues
□	□	Cough
□	□	Cancer
□	□	Stroke
□	□	Vision Problems
□	□	Ringing in Ears
□	□	Earaches
□	□	Hearing Loss
□	□	Allergies
□	□	Osteoporosis
□	□	High Blood Pressure
□	□	Weight Problems

Thoracic

Past	Present	
□	□	Mid Back Pain
□	□	Chest Pain
□	□	Heart Problems
□	□	Heartburn
□	□	Difficulty Breathing
□	□	Asthma
□	□	Ulcers
□	□	Shoulder Pain □ Left □ Right
□	□	Arthritis
□	□	Fibromyalgia

Lumbar

Past	Present	
□	□	Digestive Problems
□	□	Low Back Pain
□	□	Constipation
□	□	Diarrhea
□	□	Urinary Problems
□	□	Menstrual Problems
□	□	Diabetes
□	□	Disc Degeneration
□	□	Hip Pain □ Left □ Right
□	□	Leg pain/numbness □ Left □ Right
□	□	Knee pain □ Left □ Right
□	□	Ankle pain □ Left □ Right
□	□	Foot/Heel/Arch pain □ Left □ Right
□	□	Wear Orthotics ?

Please describe your symptoms or areas of concern with your health:
____
____

Please mark the intensity of your pain/discomfort on the scale below:

|--|---|

0 (no pain at all) 5 10 (worst pain imaginable)

How long have you had this condition? ___________ Have you had a similar condition in the past? _______________

What makes it worse? __________________________ Relieves it? ____________________________

Do you feel your symptoms have been getting: □ better □ same □ worse?

Is the pain: □ sharp □ dull □ burning □ tight □ throbbing □ numb □ tingling?

Is this condition interfering with your: □ work □ home routine □ family?

What doctors have you seen about this condition? ____

Have you seen a Chiropractor before? □ yes □ no When? _______________________________

Approximately how many visits? ________ Reason for discontinuing care _______________________