Welcome!

Your first visit to our center is an opportunity for us to learn all about you. It's a time for you to share with us where you are now in your health and life as well as what health goals you have for the future.

Personal Information

Name _____ Birth Date ____/____/____

Phone (H) _____ (W) _____ Ext. _____ (Cell) _____

Address _____
Number & Street City State Zip

Email Address _____

Would you like to receive our free health and wellness topics via e-mail? ☐ Yes ☐ No

☐ Single ☐ Married/Partnered ☐ Widowed ☐ Divorced Spouse/Partner's Name _____

# of Children ____ Names & ages_____

Employer: _____ Occupation: _____

Have you ever been to a chiropractor before? ☐ Yes ☐ No If yes, how long has it been?_____

Good results? ☐ Yes ☐ No Explain_____

Have you ever been told you have any problems/defects in your spine or nerve system? ☐ Yes ☐ No

If yes, what? _____

Please check if you are here for any of the following: ☐ Motor Vehicle Injury ☐ Work Injury

Please list any medications you currently take _____

Please list any surgeries and when_____

Please list any traumas and approximately when they occurred (car accidents, falls, broken bones, etc.)

_____

Whom may we thank for referring you to our center? _____

☐ Yellowpages ☐ Van Dyke Quarterly ☐ Website – which one? _____ ☐ Other _____

Tell Us About Your Lifestyle

PHYSICAL WELL-BEING

Do you perform a regular exercise routine? Yes No

How many days per week? _____ For how long?_____

Briefly describe the types of exercise you perform_____

_____

How many years have you been exercising regularly?_____

Are you happy with your current weight? Yes No

Are you happy with your current energy level? Yes No

Are you happy with your current level of physical health? Yes No

If not, why? _____

Rate your current Physical well-being:

Crisis 1 2 3 4 5 6 7 8 9 10 Perfect

NUTRITIONAL WELL-BEING

How would you describe the health of your eating habits on a scale of 1 to 10?

Very Poor 1 2 3 4 5 6 7 8 9 10 Perfectly Healthy

Are you satisfied with how healthy you eat? Yes No

EMOTIONAL WELL-BEING

How much stress are you under on a scale of 1 to 10?

None 1 2 3 4 5 6 7 8 9 10 Highest Possible

How much does your level of stress affect you in a negative way on a scale of 1 to 10?

Doesn't Affect Me 1 2 3 4 5 6 7 8 9 10 Makes Me Miserable

Are you happy with your current level of emotional health? Yes No

If not, why?_____

RESTING WELL-BEING

How many hours do you sleep in an average night?_____

Are you satisfied with your amount of sleep? Yes No

Are you satisfied with your quality of sleep? Yes No

If not, why?_____

Let's Find Out Why You're Here…

What is the main reason for your visit today? _____

Where are the symptoms located? (Example: right, left, middle, etc.) _____

_____

Any other specific reasons or concerns?_____

_____

_____

What is the quality of the problem? ☐ Dull ☐ Sharp ☐ Achy ☐ Stiff ☐ Sore
☐ Tight ☐ Throbbing ☐ Numb ☐ Tender ☐ Burning ☐ Tingling
☐ Shooting ☐ Radiating

When did it begin? _____

What caused the problem? _____

What is the severity? 1 2 3 4 5 6 7 8 9 10

Does the pain radiate or is it localized? _____

What is the frequency? ☐ Constant ☐ Frequent ☐ Intermittent ☐ Occasional

What makes the problem better? _____

What makes the problem worse? _____

Current or Recent Health Concerns

Symptoms are your body's way of telling you something is wrong with your health. Please check off anything that you are **currently experiencing** or have experienced **more than once in the last 6 months.**

☐ Headaches	☐ Dizziness	☐ Fatigue	☐ Depression
☐ Sore Throat	☐ Neck Discomfort	☐ Low Back Discomfort	☐ Midback Discomfort
☐ Frequent Colds	☐ Ear Aches/Infections	☐ Hand/Arm Numbness	☐ Leg/Foot Numbness
☐ Sinus Problems	☐ Anxiety	☐ Fainting	☐ Convulsions
☐ Gas/Bloating	☐ Nausea	☐ Heartburn	☐ Ulcers
☐ Diarrhea	☐ Constipation	☐ Colitis	☐ Irritable Bowel Syn.
☐ Hemorrhoids	☐ Walking Problems	☐ Shoulder Problems	☐ Heart Problems
☐ Chest Pain	☐ Asthma	☐ Allergies	☐ Short Breath
☐ Chest Congestion	☐ Lung Problems	☐ Thyroid Problems	☐ Diabetes
☐ Cancer	☐ Liver Problems	☐ Kidney Problems	☐ Blood Pressure
☐ Menstrual Problems	☐ Gall Bladder	☐ Cold Extremities	☐ Bladder Problems
☐ Prostate Problems	☐ Infertility	☐ Extremity Weakness	☐ Extremity Swelling

Please list any other health concerns not listed above_____
_____
_____

Please list any specific health problems from your family's history that you believe are significant to you_____

On a scale of 1-10, How healthy do you think you are? 1 2 3 4 5 6 7 8 9 10

On a scale of 1-10, How important is your health to you? 1 2 3 4 5 6 7 8 9 10

5 years from now, do you expect your health to be **better, worse** or **the same** as now? _____

How committed are you to moving yourself toward greater levels of health and wellness?

Not at all 1 2 3 4 5 6 7 8 9 10 100% Committed