



Confidential History and Information

Name _____ Date _____
Address _____ City _____ State _____ Zip _____
Sex Male Female Date of Birth _____ Age _____
Number of Children & Ages _____
Occupation _____ Employer _____
Employer Address _____
Work Phone _____ Home Phone _____
Cell Phone _____ Email _____
Would you like to receive our monthly email newsletter: **Yes** **No** (please circle)
Spouse/Significant other's Name _____ Employer _____
Emergency Name and Number _____
How did you hear about Back Cove Family Chiropractic? Who can we thank for referring you? _____

Your Health Profile

As a full spectrum Chiropractic Office we focus on your ability to be healthy. Our goals are first to address the issues that brought you into the office and second to offer you the opportunity for improved health potential and wellness-services in the future. On a daily basis we experience physical, chemical and emotional stress that can accumulate and result in a serious loss of health potential. Most times the effects are gradual, not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

Your Childhood Years

Research has shown that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	Yes	No	Unsure	Comments
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you fallen/jumped from a height over 3 feet (i.e. crib, bunk bed, trees?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there any prolonged use of medicine such as antibiotics or an inhaler	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any other traumas (physical or emotional?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you, were you under regular chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Your Adult Years

	Yes	No	Unsure	Comments
Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had any surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do/did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

On a scale of 1-10 describe your stress level (**1=none / 10=extreme**): Occupational _____ Personal _____

On a scale of a **Poor-Good-Excellent** describe your:

Diet: _____ Exercise _____ Sleep _____ General Health _____

Addressing the issues that brought you to this office

If you do not have a specific symptom or complaint and you are here for Wellness Services please (X) here _____

And skip to the family profile section of this form. All others please describe your chief complaint and how it has effected your life. _____

If we could help you with this problem would you like: **Temporary Relief** **Correction/Permanent Relief**

If you are experiencing pain, is it... Sharp Dull Comes and goes Travels Constant

Since the problem started, it is... About the same Getting Better Getting Worse

What makes it worse? _____

Does it interfere with... Work Sleep Walking Sitting Hobbies Leisure

Other Doctors seen for this problem (please list):

Chiropractors _____

Medical Doctors _____

Others _____

Please check boxes that describe any symptom you have ever had:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins and needles in hand/arm | <input type="checkbox"/> Diarrhea | Female Only |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pins and needles in feet/leg | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Painful menstruation |
| <input type="checkbox"/> Stiff Neck | <input type="checkbox"/> Numb fingers | <input type="checkbox"/> Ears Ringing | <input type="checkbox"/> Irregular Cycle |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Numb Toes | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Breast Problems |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Head Heavy | Are You Pregnant? |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke | |

List any medications that you take: _____

Family Health Profile

We are not only interested in your health and well-being but also about your family and loved ones. Please mention any health conditions or concerns you may have about your...

Children _____

Spouse/Partner/Significant other _____

Parents _____

Siblings _____

Others _____

Do you:

Buy bottled water? Yes No *Belong to a health club* Yes No *Consume vitamins/supplements* Yes No

The statements made from this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Signature _____

Date _____