Fife Chiropractic & Health Awareness Center
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I. Personal Information

NAME ___________________________________ LIKE TO BE CALLED "_______________________" DATE _____________
☐ MALE ☐ FEMALE AGE ______ DATE OF BIRTH _____________ SSN _____________________________
ADDRESS____________________________________ CITY ________________________ STATE _______ ZIP ___________
HOME PHONE # _____________________ CELL PHONE # ____________________ WORK PHONE # __________________
☐ SINGLE ☐ MARRIED ☐ SIGNIFICANT OTHER ☐ WIDOWED EMAIL ADDRESS _________________________________
OF CHILDREN/DEPENDENTS ________ NAME(S)/AGE/GENDER ____
OCCUPATION _________________________ EMPLOYER ____
HOW DID YOU FIND US? ☐ REFFERAL (WHO MAY WE THANK?) ____________________________________ ☐ WALK IN
☐ INSURANCE LISTING ☐ INTERNET (WEBSITE) ____________________ ☐ PHONE BOOK/YELLOW PAGES
☐ MARKETING EVENT (WHAT OR WHERE) ____

II. Your Health Profile

1. Why This Form Is Important
We want to make sure you receive the best care possible that will allow your body to function at its highest levels.
Our goals are to

- Address the concerns that brought you to our office.
- Offer you the opportunity of improved health, wellness and quality of life in the future.

2. Please briefly describe your main concern, including the effect it has had on your life:
____
____

3. **Health Concerns** List health concerns in order of importance	**Severity** 1=MILD 10=UNBEARABLE	**Date this episode started**	**If ongoing, date of last episode**	**Did problem begin with an injury?**	**Are symptoms constant or periodic?**
1. __________________	____________	___________	____________	______________	_______________
2. __________________	____________	___________	____________	______________	_______________
3. __________________	____________	___________	____________	______________	_______________

If you are experiencing pain, is it: ☐ Dull ache ☐ Sharp
Does the pain radiate/travel anywhere? ☐ No ☐ Yes - Please Explain:
____

4. **Show Us Where It Hurts:** Please mark the area of injury or discomfort using the example below.

EXAMPLE:
Numbness **NNN**
Pins & Needles **PPP**
Burning **BBB**
Aching **AAA**
Stabbing **SSS**

Circle any areas of pain not detailed with a symbol.

Since the problem started, it is: ☐ Getting Better ☐ Getting Worse ☐ About the Same
What makes it worse? ____
What have you done that makes it feel better? ____
____
What have you done that hasn't helped? ____
____
☐ **I DO** ☐ **I DO NOT** Have a family history of this or similar symptoms (if you do, please explain)
____
Is this condition interfering with your:
☐ WORK ☐ LEISURE ☐ SLEEP ☐ EXERCISE ☐ ATTITUDE ☐ HOBBIES ☐ OTHER ________________
Have you thought of and/or felt the need to make any "positive" changes due to this condition?
(For example: eat better, less alcohol/drugs, meditate, lower intensity exercise, etc) If yes, what: ________________
____

Other doctors seen for this condition: ☐ Chiropractor ☐ Medical Doctor ☐ Other
1. **Name/Address:** ____
   Date: ______________________ **What was the diagnosis?** ______________________________
2. **Name/Address:** ____
   Date: ______________________ **What was the diagnosis?** ______________________________

Who is your family doctor/primary care physician?
Name/Address: ____
Date of last check up: ______________________ Findings: ______________________________

III. General History

Please check all symptoms you have ever had. Please indicate Current with a C and Past with a P

☐ Headaches	☐ Pins & Needles in Legs	☐ Fainting	☐ Neck Pain
☐ Anxiety	☐ Pins & Needles in Arms	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Diabetes	☐ Ringing in Ears	☐ Nervousness
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleep Problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ High Blood Pressure	☐ Urinary Problems	☐ Heartburn
☐ Mood Swings	☐ Menstrual Irregularity	☐ Menstrual Pain	☐ Ulcers
☐ Allergies	☐ Sciatica	☐ Breast Lumps	☐ Muscle Cramps

List any medications and/or supplements you are taking and why: (Prescription & Non-Prescription) ______________
____
____

Please list all surgeries below:
1. Type: ______________________________ Date: __________ Is this a recurring problem? ☐ YES ☐ NO
2. Type: ______________________________ Date: __________ Is this a recurring problem? ☐ YES ☐ NO
3. Type: ______________________________ Date: __________ Is this a recurring problem? ☐ YES ☐ NO

Please list all accidents and/or injuries (auto, work related, sports, etc.) even if they don't seem relevant:

1. Type: ___________________________ Date: ____________ Hospitalized ☐ YES ☐ NO
2. Type: ___________________________ Date: ____________ Hospitalized ☐ YES ☐ NO
3. Type: ___________________________ Date: ____________ Hospitalized ☐ YES ☐ NO
4. Type: ___________________________ Date: ____________ Hospitalized ☐ YES ☐ NO

Have you ever had x-rays taken? ☐ No ☐ Yes (if yes) When: __________ Where: ________________________
Area(s) of body: ____

Please list your top 3 stresses in each category:

1. **Physical Stress** (falls, accidents, posture, etc.)
   A. ____
   B. ____
   C. ____

2. **Bio-chemical Stress** (smoke, unhealthy foods, missed meals, drugs, chemicals, etc.)
   A. ____
   B. ____
   C. ____

3. **Emotional Stress** (work, divorce, finances, death, self-esteem, etc.)
   A. ____
   B. ____
   C. ____

IV. The Early Years (birth to 17 years old)

Research is showing that many of the health challengers we face as adults started in the developmental years, often as early as birth. Please answer the following questions as honestly & accurately as possible.

	YES	NO	UNSURE
1. Did you have any serious childhood illnesses?	☐	☐	☐
2. Did you have any serious falls as a child?	☐	☐	☐
3. Did you play youth sports?	☐	☐	☐
4. Did you take/use any drugs (prescribed or not)?	☐	☐	☐
5. Did you have any surgery?	☐	☐	☐
6. Did you have any serious accidents?	☐	☐	☐
7. Did you have any prolonged use of medications like antibiotics or inhalers?	☐	☐	☐
8. Did you suffer any other traumas physical or emotional?	☐	☐	☐
9. Were you vaccinated?	☐	☐	☐
10. Did you receive regular chiropractic care?	☐	☐	☐
11. Have you ever received the flu shot?	☐	☐	☐

Comments: ____
____
____
____
____

IV. The Adult Years (18 to present)

	YES	NO
1. Do/did you smoke?	☐	☐
2. Do/did you drink alcohol (more than socially)?	☐	☐
3. Have you been in an accident (car, work, or a fall)?	☐	☐
4. Have you had any surgery?	☐	☐
5. Do/did you play adult sports?	☐	☐
6. Do/did you play extreme sports?	☐	☐

On a scale of 1 to 10, <u>1 being very poor</u>, <u>10 being excellent</u>, rate your:

Diet:	1	2	3	4	5	6	7	8	9	10
Exercise:	1	2	3	4	5	6	7	8	9	10
Sleep:	1	2	3	4	5	6	7	8	9	10
Mind-set:	1	2	3	4	5	6	7	8	9	10
Overall Health:	1	2	3	4	5	6	7	8	9	10

On a scale of 1 to 10, <u>1 being none</u>, <u>10 being extreme</u>, rate your emotional stress levels:

Occupational:	1	2	3	4	5	6	7	8	9	10
Personal:	1	2	3	4	5	6	7	8	9	10

V. Family Health Profile

At our center, we are interested in the health and well-being of your friends, family and loved ones, in addition to you. Please list their names and any health concerns they may have:

Children: ____

Spouse: ____

Mother: ____

Father: ____

Brothers: ____

Sisters: ____

Others: ____

VI. Closing Notes

	YES	NO
1. Do you consistently buy bottled water?	☐	☐
2. Do / Did you belong to a gym or health club?	☐	☐
3. Have you taken vitamins or minerals?	☐	☐
4. If there is a need for dietary changes or nutrients, would you like to be informed?	☐	☐
5. If there is a need to specific exercises, would you like to be informed?	☐	☐
6. If there is a need for support in the psychological / mind / body / stress dimension of health, would you like to be informed?	☐	☐

I consent to a professional chiropractic examination and to any radiographic (x-ray) examination the doctor recommends. I understand that any fee for service (s) rendered is due at the time of service and cannot be deferred to a later date.

Printed Name ____

Signature ______________________________________ Date ________________

Please fill out pages 5 - 6 only if you were involved in work or auto accident.

Auto or Work Related Accident

1. About You

NAME ____ TODAY'S DATE ____________________

2a. Auto Related Accident

Date of Accident: _____________ **Time of Accident:** ________ ☐ a.m. ☐ p.m. # of people in vehicle:_____

1. Did the police come to the accident site? ☐ YES ☐ NO
2. Was a police report filed? ☐ YES ☐ NO
3. Was a traffic violation issued? ☐ YES ☐ NO If "yes", to who? __________________________
4. Were there witnesses? ☐ YES ☐ NO
5. Were you surprised by the impact? ☐ YES ☐ NO
6. **About your vehicle:**
   a. Name of the location / street you were traveling on: ____
   b. Make / Model / Year of your vehicle: ____
   c. Direction you were heading: ____
   d. Estimated speed: ____
   e. Your vehicle was impacted on the: ☐ Front ☐ Rear ☐ Right side ☐ Left side ☐ Other
   f. During impact, you were facing: ☐ Right ☐ Left ☐ Forward ☐ Backwards
   g. Were you wearing your seat belt? ☐ Yes ☐ No
   h. Did your vehicle have airbags? ☐ Yes ☐ No
   If "yes", did they inflate? ☐ Yes ☐ No
   i. In relation to the base of your skull, where was the headrest?
   ☐ Above ☐ Below ☐ At the base of skull
   j. What did your vehicle impact? ☐ Another vehicle ☐ Other: __________________________
   k. Did any part of your body strike anything in the vehicle? ☐ Yes ☐ No
   If "yes", please explain: ____
7. **If another vehicle was involved:**
   a. Make / Model / Year: ____
   b. Direction traveling: ____
   c. Estimated Speed: ____________ mph
8. Please describe the accident: ____

____

____

2b. Work Related Accident

Date of Accident: _____________ **Time of Accident:** ________ ☐ a.m. ☐ p.m.

Was accident directly work related? ☐ YES ☐ NO

1. Please describe the events immediately before and during the accident: ____________________________

____

2. Location / Address of accident: ____
3. Were there witnesses? ☐ YES ☐ NO
4. Did you report the accident to your employer? ☐ YES ☐ NO
5. What recommendations did you employer make immediately after you reported accident? __________

____

6. Have you had this type of accident before? ☐ YES ☐ NO
7. To your knowledge, has this type of accident happened in your workplace before? ☐ YES ☐ NO
8. Is your job physically stressful? ☐ YES ☐ NO
9. Is your job mentally stressful? ☐ YES ☐ NO

3. After Injury

1. Were you ever unconscious? ☐ YES ☐ NO If "yes", how long? ____
2. Describe how you felt right after the accident: ____
3. Have you seen any other doctor? ☐ YES ☐ NO If "yes", who & where: ___________________________________
4. Describe any treatment you have received: ____
5. Were x-rays taken? ☐ YES ☐ NO If "yes", what part of your body was x-rayed? ___________________________
6. Was medication prescribed? ☐ YES ☐ NO
7. Have you worked since this injury? ☐ YES ☐ NO
8. Are your activities restricted? ☐ YES ☐ NO
9. Check the symptoms resulting from this accident:

☐ Dizziness	☐ Sleep Problems	☐ Low Back Pain	☐ Mid Back Pain	☐ Fatigue
☐ Tension	☐ Memory Loss	☐ Headache(s)	☐ Blurred Vision	☐ Leg Pain
☐ Nausea	☐ Arm/Shoulder Pain	☐ Ringing in Ears	☐ Chest Pain	☐ Numb toes/feet
☐ Neck Pain	☐ Irritability	☐ Upset Stomach	☐ Stiffness	☐ Other

10. Is you condition: ☐ Stable ☐ Improving ☐ Worsening ☐ Varies
11. Rate your comfort level performing these activities:

	Comfortable	**Uncomfortable**	**Painful**
Lying on back	☐	☐	☐
Lying on side	☐	☐	☐
Lying on stomach	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Stretching	☐	☐	☐
Sex	☐	☐	☐
Walking	☐	☐	☐
Running	☐	☐	☐
Sports	☐	☐	☐
Working	☐	☐	☐
Lifting	☐	☐	☐
Bending	☐	☐	☐
Kneeling	☐	☐	☐
Pulling	☐	☐	☐
Reaching	☐	☐	☐

4. Recovery

1. How many hours do you work a day? _________________ hours
2. Please indicate your daily job duties and any activities which you are occasionally asked to perform:

☐ Standing	☐ Driving	☐ Operating Equipment
☐ Sitting	☐ Twisting	☐ Work with arms above head
☐ Walking	☐ Crawling	☐ Typing
☐ Lifting	☐ Bending	☐ Stooping

☐ Other ____

3. Prior to your injury, were you able to do the same work as others your age? ☐ YES ☐ NO
4. Can you request light duty during recovery? ☐ YES ☐ NO

5. Additional Insurance – Auto Insurance or Workers Compensation

Type of Insurance: _____________________ Insurance Company Name: ____________________________________
Adjustors Name: ________________________________ Adjustors Phone Number: ___________________________
Claim Number: __________________________________ Insured's Name: ___________________________________
Insured's DOB: __________________________________ Insured's SSN: ____________________________________