

## CONFIDENTIAL PATIENT INTRODUCTION

### PERSONAL INFORMATION:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone# \_\_\_\_\_ Work Phone# \_\_\_\_\_ Cell Phone# \_\_\_\_\_

Email Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Marital Status: Single Married Divorced Widowed Occupation: \_\_\_\_\_

Who were you referred by? \_\_\_\_\_

Children's Names & Ages: \_\_\_\_\_

### YOUR HEALTH:

0-50 Very Challenged	50-75 Challenged	75-100 Transition	100-125 Good	125+ Excellent
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Please Place an "X" on the scale above marking where you believe your level of health and wellness is at this Time.  
Place a circle "O" on the scale indicating where you would like your health and wellness to be.

### YOUR HEALTH PROFILE:

What brings you into our office? Please briefly describe your chief concern, including the impact it as had on your life. If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History" page.

Health Concerns:	Rate Severity 1=mild 10=worse imaginable	When did this start?	Are symptoms Constant or Intermittent?	Did problem begin with injury?
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Please explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What makes the problem worse? \_\_\_\_\_

What does this interfere with? Work \_\_\_\_\_ Leisure \_\_\_\_\_ Sleep \_\_\_\_\_ Sports \_\_\_\_\_ Other \_\_\_\_\_

**General History:**

Since the problem started, it is: The Same \_\_\_\_\_ Getting Better \_\_\_\_\_ Getting Worse \_\_\_\_\_

List all medications you are taking and why: (Prescription & Non-Prescription) \_\_\_\_\_

\_\_\_\_\_

Have you had any surgeries or hospitalizations? (Please list all surgeries) \_\_\_\_\_

\_\_\_\_\_

Have you ever had any slips, falls or auto accidents? \_\_\_\_\_

\_\_\_\_\_

Please place an "X" beside all symptoms you have ever had, even if they do not seem related to your current problem:

Headaches	Pins & Needles in Legs	Fainting	Neck Pain
Dizziness	Pins & Needles in Arms	Loss of Balance	Back Pain
Buzzing in Ears	Ringing in Ears	Loss of Smell	Nervousness
Numbness in Fingers	Numbness in Toes	Loss of taste	Stomach Upset
Fatigue	Depression	Irritability	Tension
Sleeping Problems	Stiff Neck	Cold Hands	Cold Feet
Diarrhea	Constipation	Fever	Hot Flashes
Cold Sweats	Lights Bother Eyes	Urinary Problems	Heartburn
Mood Swings	Menstrual Pain	Menstrual Irregularity	Ulcers

**Family Health Profile:**

At our office we are not only interested in your health and well being but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: \_\_\_\_\_

Spouse: \_\_\_\_\_

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Others: \_\_\_\_\_

Do you spend 2 hrs or more per day on a computer? Yes \_\_\_\_\_ No \_\_\_\_\_

If there is a need for dietary changes would you like to know about them? Yes \_\_\_\_\_ No \_\_\_\_\_

**On a scale of 1-10 describe your psychological/emotional stress levels:**

(1=none/10=extreme)

Occupational: \_\_\_\_\_

Personal: \_\_\_\_\_

What do you do for stress relief? \_\_\_\_\_

**On a scale of 1-10 describe the following:**

(1 being poor/10 being excellent)

Immune System \_\_\_\_\_ Eating Habits \_\_\_\_\_ Exercise Habits \_\_\_\_\_ Sleep \_\_\_\_\_ General \_\_\_\_\_ Health Mind Set \_\_\_\_\_

In the last week how many times did you exercise? \_\_\_\_\_

**Your Goals:**

At our office we concern ourselves with YOUR health and YOUR wellness goals. Please list your goals for your health and wellness in the spaces provided.

**Physical Goals:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Nutritional/Biochemical Goals:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Psychological Goals:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please answer the following:**

Do you buy bottled water? Yes \_\_\_\_\_ No \_\_\_\_\_

Belong to a health club? Yes \_\_\_\_\_ No \_\_\_\_\_

Consume vitamins or supplements? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you watch more than 2 hrs of TV per day? Yes \_\_\_\_\_ No \_\_\_\_\_

If there is a need for special exercises would you like to know about them? Yes \_\_\_\_\_ No \_\_\_\_\_

If there is a need for support in the psychological/mind/body/stress dimension of health would you like assistance? Yes \_\_\_\_\_ No \_\_\_\_\_

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Thank you for filling out this form. It is your first step to Creating Wellness!

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**One Clinic**  
*Optimal Health*

familyhealth  
chiropractic   
Dr. Alisa (Ali) Miller, BSc., D.C.

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