Beach House chiropractic
life at your best

Patient Information

Name ______________________________ Date of Birth ______________
Address ______________________________ Post code ______________

Home phone (______) ______________ Work phone (______) ______________ Mobile ______________

Occupation ______________ Email ______________________________

Status (please tick): ☐ Single ☐ Married ☐ Divorced ☐ Widowed Number of children ______ Ages ______

Private Insurance Co. ______________ Will you be claiming insurance? (please tick) ☐ Yes ☐ No

Reason for consultation: ______________________________

____

Whom may we thank for referring you to our clinic? ______________________________

Your Health Profile

Why This Form Is Important

As a wellness based chiropractic clinic, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to us, and second, to offer you the opportunity of improved health potential in the future. On a daily basis we experience **physical, chemical and emotional stresses** that can accumulate and result in 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.

The Early Years (to age 16)

Research is showing 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.

Your Childhood Years	**Yes**	**No**	**Unsure**
Did you have any serious falls or physical traumas as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Any prolonged use of medicines such as antibiotics or an inhaler?	☐	☐	☐
As a child were you under regular Chiropractic care?	☐	☐	☐

Comments: ______________________________

____

Adult (18 to present)	**Yes**	**No**	**Unsure**
Do/did you smoke?	☐	☐	☐
Do/did you drink alcohol?	☐	☐	☐
Have you been in any accidents?	☐	☐	☐
Have you had any surgery?	☐	☐	☐
Do/did you take any medications/drugs?	☐	☐	☐
Do/did you play any adult sports?	☐	☐	☐

On a scale of 1 to 10 describe your stress level: (1 = none, 10 = extreme)

Occupational _____ Personal _____

On a scale of Poor, Good or Excellent, please rate your:

Diet: _________ Exercise: ___________ Sleep: _________ General health: ___________

On a scale of 0-10 (10 being Excellent), rate your quality of life: ________

Addressing the issues that bought you to this office

If you have no symptoms or complaints and are here for Wellness Services, please tick here ☐ and then please skip to '**Health Profile**'. Otherwise, briefly describe the chief area of complaint.

What is your chief complaint
(and cause if known): ____

If you are experiencing pain, is it: ☐ Sharp ☐ Dull ☐ Intermittent (comes & goes) ☐ Constant

How long have you been experiencing this problem? ____

Since the problem has started, is it: ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse? ____

Indicate what your present condition is affecting: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Rate your level of pain (please circle): No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

Other Doctors seen for this problem (please list):

Chiropractor: ____

Medical Doctor: ____

Other: ____

Health Profile

Please tick all the symptoms you have ever had, even if they do not seem related to your current problem.

☐ Headaches
☐ Migraines
☐ Neck Pain
☐ Mid back pain
☐ Low back pain
☐ Shoulder pain
☐ Arm/wrist pain

☐ Hip pain
☐ Leg pain
☐ Knee/Ankle pain
☐ Pins & Needles

☐ Arthritis
☐ Morning stiffness
☐ Fatigue
☐ Dizziness
☐ Fainting
☐ Ringing in ears
☐ Heart trouble
☐ High blood pressure
☐ Poor circulation
☐ Palpitations
☐ Chest pain
☐ Liver problems

☐ Asthma
☐ Breathing problems
☐ Blurred vision
☐ Indigestion
☐ Constipation
☐ Kidney problem
☐ Bladder problems
☐ Prostate trouble
☐ Diabetes
☐ Allergies
☐ Hot sweats
☐ Cancer

☐ Sleep problems
☐ Depression
☐ Panic Attacks
☐ Other: ______________

Women Only
☐ Hot Flushes / Night sweats
☐ Heavy menstruation
☐ Painful menstruation
☐ Irregular cycle

For Women Only (we require the following information)
Date of your last period: ……………………………………….
Is there any possibility of you being pregnant? (please tick) ☐ Yes ☐ No

Family Health Profile

At our clinic we are interested in your health and well being AND the health and well being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: ______________________ Brothers: ______________________

Spouse: ______________________ Sisters: ______________________

Parents: ______________________ Others: ______________________

The statements made on this form are accurate to the best of my recollection. I allow this office to examine me for further evaluation. I also agree that any x-rays taken by this clinic are an important part of the patient's permanent records and as such remain the property of the clinic.

Signed: ______________________________________ **Date:** ____________________