Shrewsbury Family Chiropractic

Name: _____ Age: _____Date: _____

Address: _____
Residence and Mailing City State Zip/Postal Code

Home Telephone ( )_____ Work Phone ( )_____ Male_____ Female _____

E-mail Address: _____Cell Phone ( )_____Birthday _____

Occupation _____

Single _____ Married _____ Divorced _____ Widowed _____ Spouse's Occupation _____

No. of children: _____ Age of children: _____

Reason for consulting our office? _____

Who may we "Thank" for referring you to our office? _____

Your Health Profile

WHY THIS FORM IS IMPORTANT

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 to this office, and second, to offer you the opportunity of improved health potential and wellness services 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 BEGINNING YEARS (To Age 17)
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 childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take/use any drugs?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree)	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐

	YES	NO	UNSURE
Was there any prolonged use of medicines such as antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other Traumas? (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
As a child, were you under Regular Chiropractic care?	☐	☐	☐

COMMENTS:_____
_____

ADULT –(18 to Present)

	YES	NO
Do/did you smoke?	☐	☐
Do/did you drink?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐

	YES	NO
Do/did you play any adult sports?	☐	☐
Do/did you participate in extreme sports?	☐	☐

On a scale of 1-10 describe your stress level:
(1=None/10=Extreme)
Occupational _____Personal _____

On a scale of Poor, Good or Excellent describe your:
Diet _____ Exercise _____ Sleep _____ General Health_____

Addressing The Issues That Brought You To The Office

Please check one of the following:

____ I have no special problem; I understand the role of chiropractic in my general health care.

____ I have the symptom of a physical problem. I want to see if chiropractic will enable my body to work better and have a greater potential to heal itself. I am also interested in learning about the role of chiropractic in improving and maintaining my health and my family's health.

____ I have a symptom and I am only interested in the relief from it.

If you have a specific issue which caused you to consult this office, briefly describe it, including the effect it has had on your life. _____
_____

List any medications you are taking. _____
_____
_____

Family Health Profile:

At our office, we are not only interested in your health and well-being, but also 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 _____

Spouse _____

Mother _____

Father _____

Brothers _____

Sisters _____

Others _____

Have you ever:

Bought bottled water: □ **Yes** □ **No**
Belonged to a health club: □ **Yes** □ **No**
Consumed vitamins or supplements: □ **Yes** □ **No**

The statements made on 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