

Shrewsbury Family Chiropractic

FULL NAME: _____ Home Phone () _____
 Street _____ Cell Phone () _____
 City _____ State _____ Zip _____ Cell Carrier _____
 E-mail Address: _____ **DOB** _____
 Male ___ Female ___ Other ___ Single ___ Married ___ Divorced ___ Widowed ___
 No. of children: _____ Age of children: _____ Height _____ Weight _____
 Who may we "Thank" for referring you to our office? _____
 Occupation _____ Spouse's Occupation _____
 Reason for consulting 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		YES	NO	UNSURE
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was there any prolonged use of medicines such as antibiotics or an inhaler?	<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 suffer any other Traumas? (physical or emotional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	As a child, were you under Regular Chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Have you fallen/jumped from a height Over three feet? (i.e. crib, bunk bed, tree)	<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"/>				

COMMENTS: _____

ADULT – (18 to Present)	YES	NO		YES	NO
Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>
Do/did you drink?	<input type="checkbox"/>	<input type="checkbox"/>	Do/did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	On a scale of 1-10 describe your stress level: (1=None/10=Extreme)		
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Occupational _____ Personal _____		
On a scale of Poor, Good or Excellent describe your:					
Diet _____	Exercise _____		Sleep _____	General Health _____	

Addressing the Issues That Brought You To Our 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 or supplements 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