## General Information

Name_____ Birthdate____/____/____ Age_____ Today's date____/____/____

Address_____ City_____ State_____

Zip_____ Soc. Sec. #_____-_____-_____ Driver's License #_____

Home # (  )_____ Work # (  )_____Ext.____ Fax # (  )_____

Beeper/Cellular # (  )_____ E-Mail Address_____

Occupation_____ Employer's Name_____

Employer's Address_____ City_____ State_____Zip_____

____Male ____Female # of Kids_____ ____Single ____Married ____Divorced ____Widowed

Name of Spouse_____ Names of Kids_____

Reason for consulting our office?

_____

_____

_____

Referred by_____

**Please check if you are here for any of the following: _____Motor Vehicle Accident _____Work Injury _____Other Injury

## Your Health Profile

Why this form is important - As a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a lifetime of health, happiness and vitality. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious, and sometimes not until it's too late! Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better assess your current status and more accurately determine your true health potential.

The Beginning Years - Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

**Birth History** - Please check those items that apply to you

____**Mother smoked/drank/drugs in pregnancy** ____**Epidural/Meds in labor** ____Breech Vaginal Delivery ____C-Section

____Forceps Delivery ____Vacuum Extractor used ____Labor Induced

____Complications

____Other_____

_____

**Childhood Years** (Age 0-17 yrs) - Please check those items that apply to you

____Childhood Illness ____**Serious Falls** ____Active in Sports

____Very Inactive

____Car Accident(s) ____Surgery/Stitches ____Alcohol/Drug Abuse

____Smoker

____**Antibiotics/Other Meds** ____Vaccinated ____Under Chiropractic care

____Broken Bones

____Severe Emotional Trauma(s)_____

**Adult Years** (Age 18 to present) - Please check those items that apply to you

____Present Smoker ____Former Smoker ____OTC/Prescription Meds

____Alcohol Use

____Surgery/Stitches ____Play Sports ____Car Accidents

____Work Injury

____High Job Stress ____**High Personal Stress** ____Sit a lot

____Drive a lot

____Poor Sleep ____Not Enough Sleep ____Poor/Inadequate Diet

____No Exercise

____Flat Feet ____Wear Orthotics/Lifts ____Severe Health Problems

____Hard Falls

____Broken Bones ____Other Injuries_____

____Have been under chiropractic care in the past - How long ago was your last adjustment?

_____

(Over Please)

Addressing the issues that brought you to our office

**If you have no symptoms or complaints and you are here for wellness care, please check here ____"Wish to have Chiropractic Wellness Services" and skip to "Family Health Profile" near the bottom of this form. Otherwise, please continue.

Chief Complaint(s):

_____

_____

_____

How has this affected your life?

_____

_____

_____

If you have pain, is it... ____Sharp ____Dull ____Constant ____Intermittent ____Traveling ____Radiating

____Mild ____Moderate ____Moderately Severe ____Severe ____Intolerable

Since it began, is it... ____About The Same ____Getting Better ____Getting Worse ____Variable

What makes it worse?

_____

What makes it better?

_____

Does it interfere with... ____Work ____Sleep ____Walking ____Sitting ____Exercise ____Hobbies ____Leisure Activities

Did you have an injury? ____Yes ____No If Yes, please explain_____

_____

_____

How long have you had this problem?

_____

Is there a time of day that it is worse typically? ____Yes ____No If Yes, when?

_____

Other doctors/treatments you've tried for this problem (Please list):_____

_____

Chiropractor_____

_____

____Medical Doctor_____

____Other_____

_____

**Please check all recurring or severe symptoms you have ever had, even if they do not seem related to your current problem(s).

___Headaches/Migraines ___Pins & Needles in Legs/Feet ___Recurring Infection

___Infertility/Impotence/Miscarriage

___Pins & Needles in arms ___Loss of Smell ___Back Stiffness/Pain

___Loss of Balance

___Dizziness/Vertigo ___Buzzing/Ringing in ears ___Sinus Problems/Allergies

___Nervousness/Anxiety

___Numbness in fingers ___Numbness in toes ___Loss of Taste

___Stomach Upset

___Fatigue ___Depression ___ Irritability/Mood Swings

___Tension/Stress

___Sleeping Problems ___Neck Stiffness/Pain ___Cold Hands

___Cold feet

___Diarrhea/Constipation/Gas ___Foot Problems ___Shortness of Breath

___Hot Flashes

___Cold Sweats ___Light Bothers Eyes ___Problems Urinating

___Heartburn/Reflux

___High Blood pressure ___Pre-Menstrual Syndrome (PMS) ___Menopause

___Ulcers

___Jaw/TMJ Problems ___Other

_____

**Family Health Profile** - In our office, we are not only interested in your health & well being, but also in that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children_____

Spouse_____

Parents_____

Siblings_____

Others_____

Have you ever:

| | | |
|---|---|---|
| Bought Bottled Water? | ____Yes | ____No |
| Belonged to a Health Club? | ____Yes | ____No |
| Consumed Vitamins or Supplements? | ____Yes | ____No |

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge.
I agree to allow this office to examine me for further evaluation.

_____ ____/____/____
Signature Date

Please give the receptionist or the doctor your insurance card as we will file and process your insurance for you. Whether your insurance pays for your office visit depends on the contract between you and your insurance carrier. Lettman Chiropractic Rehab is on most insurance plans and we will let you know if you're covered before you are seen!