Creating Wellness

Rossi Family Chiropractic
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Your Health Profile

Personal Information

NAME: ______ PATIENT#: ______ AGE: ______ DATE: ______

ADDRESS: ______

CITY / STATE / ZIP: ______

HOME PHONE #: ______ WORK PHONE#: ______ CELL#: ______

E-MAIL ADDRESS: ______ MALE ______ FEMALE ______

BIRTH DATE: ______ BEST TIME & NO. TO CONTACT: ______

OCCUPATION ______ EMPLOYER'S NAME AND ADDRESS: ______

SINGLE: ______ MARRIED: ______ DIVORCED: ______ WIDOWED: ______

NO OF CHILDREN: ______ NAMES, AGES AND GENDER: ______

______

______

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFICE? ______

Your Health Profile

Why This Form Is Important

As a Creating Wellness Center, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your health potential .

Addressing what brought you to this office

If you have no symptoms or complaints and are here for Chiropractic Wellness Services , please skip to the "General History ." (next page)

Others, please briefly describe your chief concern, including the effect it has had on your life.

______

______

Health Concerns: List health concerns according to their severity.	Rate of Severity 1= mild 10= worst imaginable	When did this episode start?	If you had the condition before, when?	Did problem begin with an injury?	Are symptoms constant or intermittent?
1.					
2.					
3.					
4.					

If you are experiencing pain, is it…

☐ Sharp ☐ Dull ache

Does the pain travel/radiate anywhere: ☐ no ☐ yes - please describe

______

______

Since the problem started, it is... ▯ About the same ▯ Getting Better ▯ Getting Worse

What makes it worse? ______________________________

What have you done for this condition that has helped you feel better? ______________________________

____

What have you done for this condition that was of no help? ______________________________

____

▯ I do ▯ do not have a family history of this or similar symptoms (if you do, please explain)

____

____

Is this condition interfering with your: ▯ Work ▯ Leisure ▯ Sleep ▯ Sports/exercise/walking,
▯ Positive mental attitude ▯ Hobbies ▯ Other ______________________________

Have you had to, or felt the need to make any "positive" changes in your life due to your condition? (i.e., eat better, less alcohol or drugs, meditate, less destructive sports, activities, etc.) if so what?

____

____

____

Other Doctors seen for this condition: ▯ Chiropractor ▯ Medical Dr. ▯ Other

1. Name/Address: ______________________________
   Date: ______________ What was the diagnosis? ______________
   What was done? ______________________________
2. Name/Address: ______________________________
   Date: ______________ What was the diagnosis? ______________
   What was done? ______________________________

General History:

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

▯ Headaches	▯ Pins and needles in legs	▯ Fainting	▯ Neck pain
▯ Pins and needles in arms	▯ Loss of smell	▯ Back Pain	▯ Loss of balance
▯ Dizziness	▯ Buzzing in ears	▯ Ringing in ears	▯ 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 Problem	▯ Heartburn
▯ Mood Swings	▯ Menstrual Pain	▯ Menstrual Irregularity	▯ Ulcers

List any medications you are taking and why: (**prescription** and **non-prescription**)

Have you had any surgery? (Please include all surgery)

1. Type ______ Date ______ Doctor ______
2. Type ______ Date ______ Doctor ______
3. Type ______ Date ______ Doctor ______
4. Type ______ Date ______ Doctor ______

Accidents and/or injuries: auto, work related, or other (especially those related to your present problems).

1. Type ______ Date ______ Hospitalized ☐ Yes ☐ No
2. Type ______ Date ______ Hospitalized ☐ Yes ☐ No
3. Type ______ Date ______ Hospitalized ☐ Yes ☐ No

Have you ever had x-rays taken? (if yes) When ______ Where ______

Area of body: ______

Do you wear orthotics or heel lifts? ☐ Yes ☐ No

Please list your top three stresses in each category:

1. Physical stress (falls, accidents, work postures, etc.)
   a. ______
   b. ______
   c. ______
2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, etc.)
   a. ______
   b. ______
   c. ______
3. Psychological stress (work, relationships, finances, self-esteem, etc.)
   a. ______
   b. ______
   c. ______

The Beginning Years

Research is showing that many of the health challenges that occur later in life originated during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Birth to 17 years of age	Yes	No	Unsure
Did you have any serious childhood illnesses?	☐	☐	☐
Did you have any serious falls as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take /use any drugs (prescribed or not)?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Were you involved in any car accidents?	☐	☐	☐
Was there prolonged use of medicine such as Antibiotics or an inhaler?	☐	☐	☐
Did you suffer any other traumas? (physical or emotional)	☐	☐	☐
Were you vaccinated?	☐	☐	☐
Were you under regular Chiropractic care?	☐	☐	☐

COMMENTS: ______

Adult-(18 to present)

	YES	NO
Do/did you smoke?	▯	▯
Do/did you drink alcohol (more than socially)?	▯	▯
Have you been in any accidents?	▯	▯
Have you had any surgery?	▯	▯
Do you play any adult sports?	▯	▯
Do/did you participate in extreme sports?	▯	▯

On a scale of 1-10 describe your psychological/emotional stress levels: (1= none/ 10=extreme)

Occupational: ______________________________

Personal: ______________________________

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating habits: __________ Exercise habits: __________ Sleep: __________

General Health: __________ Mind-set: __________

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 list below their names and any health conditions or concerns they may have:

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
If there is a need for dietary changes or nutrients would you like to be informed?	▯ Yes	▯ No
If there is a need for specific exercises would you like to be informed?	▯ Yes	▯ No
If there is a need for support in the psychological/mind/body/stress dimension of health would you like to be informed?	▯ 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!**
Return this to our staff and someone will be right with you.