WINFIELD CHIROPRACTIC RELIEF & WELLNESS

Patient Information & Forms

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1. WELLNESS / PREVENTION

If you are here for **WELLNESS** / **PREVENTION** services, please check here: _____

What are your **HEALTH** objectives? _____

_____

Name/Address/Phone of the last doctor who put you on a **HEALTH DEVELOPMENT PRGRAM**?

_____

Were you able to stay on the program?_____ How long?_____

What were your results? _____

Were your results permanent? _____

Are you **HEALTHIER** today than you were **5** years ago? _____

If so, what did you do to **IMPROVE** your health? _____

If not, why do you think your **HEALTH** declined?_____

Will you be **HEALTHIER 5** years from now than you are today? _____

If so, what are you planning to do to **IMPROVE** your health and if not, what could you do to **IMPROVE** your health rather than have it continue to decline?_____

What are your **TOP 3 GOALS** for your **HEALTH** 5 years from now? _____

_____

_____

Please **CIRCLE** a box in each categrory the best describes you.
Example "*OK energy*" from the **Energy Levels** category

Energy Levels	Ability To Handle Stress	Quality of Sleep	Physical Health & Symptoms	Mental / Emotional State
Vibrant & energetic	Extremely adaptable to stress	Optimal sleep	Peak physical health	Joy & happiness, zest for life, cant wait to get up in the morning
High energy	Handle stress well	Excellent sleep	Feel good, strong & flexible	Positive & happy most of the time, clear thinking, good memory
Up & down energy	Up & down stress	Good sleep	Occasional ups & downs, feel good and strong most of time	Feel good, slight amount brain fog & memory trouble
OK energy	Average stress	Moderate sleep	Feel OK, occasional minor pain	Emotional ups & downs "normal" brain fog & memory trouble
Tired	Moderate stress	Fair sleep	Constant aches, pains & symptoms	Slight depression or anxiety, irritable
Fatigued	Extremely stressed	Poor sleep	Chronic disease and acute episodes	Moderate depression or anxiety
Exhausted	Can't cope	Severe insomnia	Serious Chronic disease & illness	Serious depression or anxiety

Patient Name_____ Date_____

2. LIFESTYLE HABITS / MEDICATIONS/ SUPPLEMENTS

Activity		Frequency per week	Duration in Minutes
Stretching	□Yes □No		
Walking/Running	□Yes □No		
Strength Training	□Yes □No		
Other (Pilates, yoga, boxing etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading etc.)			

How many hours of television do you watch a day? □ 0 □ 1-2 □ 3-5 □ > 5

How many hours per day do you ride in a car or other vehicle? □ 0 □ 1-2 □ 3-5 □ > 5

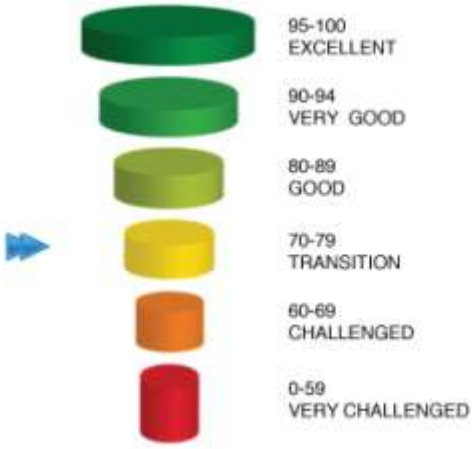
Have you ever used tobacco? □ Never □ Past □ Weekly □ Monthly □ Yearly

How many servings of alcohol do you drink each week? □ 0 □ 1-2 □ 3-5 □ > 5

How many servings of coffee do you drink each week? □ 0 □ 1-2 □ 3-5 □ > 5

How many servings of soda do you drink each week? □ 0 □ 1-2 □ 3-5 □ > 5

Please mark an "X" where you believe your health is and an "O" where you would like to be.



DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? _____

MEDICATION or SUPPLEMENT LOG **List the type of medications or supplements you are taking now.**

Medication or Supplement Name	Date started	Dated Stopped	Reason for use

Patient Name_____ Date_____

3. FAMILY & SELF HISTORY

(Indicate with the bold letter below) **: *F***ather, ***M***other, ***B***rother, ***S***ister, ***U***ncle, ***A***unt, ***GM***-grandmother, ***GF***-grandfather, ***self***)

Cancer, type:
Heart disease:
Hypertension:
Stroke:
High Cholesterol:
Diabetes:
Weight Problems:
Arthritis:
Low Back pain:
Headaches:
PMS:
Other:
Is there any other family history we should know about? □Yes □No
If yes, please comment

Prior Injuries: □ **No History of previous injury or pain.** (Please indicate when and describe how the injury occurred.)

☐ Fall Injury	_____
☐ Lifting Injury	_____
☐ Work- Job Related Injury	_____
☐ Bicycle Injury	_____
☐ Pedestrian Injury	_____
☐ Military Injury	_____
☐ Car Accident	_____
☐ Motorcycle Injury	_____
☐ Other_____	_____
☐ Other_____	_____
☐ Other_____	_____

Previous Surgeries: □ **No history of surgical procedure.** (If any previous surgery, type and when.)

	Surgery ***Year***
☐ Hernia	_____
☐ Rib/Collar bone:	_____
☐ Shoulder/Elbow/Wrist/Hand:	_____
☐ Gallbladder/Stomach/Kidney:	_____
☐ Disc surgery (neck or back):	_____
☐ Spine Surgery (neck or back):	_____
☐ Thigh/Knee/Ankle/Foot:	_____
☐ Hip Replacement	_____
☐ Heart:	_____
☐ Cancer	_____
☐ Other	_____

Fractures/Broken Bones: □ **No History of fracture** For fracture/broken bones indicate LEFT / RIGHT and when the fracture occurred.) _____

Patient Name_____ Date_____

4. REVIEW OF SYSTEMS

Please check (✓) any symptoms you currently have, even if they do not seem relateded 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	☐ Irregular Cycles	☐ Ulcers
☐ Sinus Problems	☐ Earaches	☐ Asthma	☐ Sore Throat
☐ Bronchitis	☐ High Blood Pressure	☐ Low Blood Pressure	☐ Chest Pain
☐ Shoulder Pain	☐ Arm Pain	☐ Knee Pain	☐ Foot Pain

5. FAMILY HEALTH PROFILE

At our office we are not only interested in your health and wellbeing but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brother(s): _____

Sister (s): _____

Others: _____