WINER CHIROPRACTIC CENTER

PLEASE PRINT

Full Name:_________________________________ Email Address:____________________ Date: ______

Social Security Number: ______________ Date of Birth: ______________ Age: _______ Male Female

Name of Spouse/Significant Other if applicable: _______________________# of Children & Ages: ______

Home Address: _____________________________ City:_______________State: ______ Zip: _________

Home Phone #: _____________Work Phone #: _______________Mobile Phone #: __________________

Employer: ____________________________Employer Address: ___________________________________

City: ____________ State: ____Zip: _______ Emergency Name and Number: _______________________

How did you hear about our office?____

If someone referred you, what is their name? ____

Why are you consulting our office at this time? ____

____

YOUR HEALTH PROFILE

If you have no complaints and you are here for Chiropractic Wellness Services, please (X) here ______

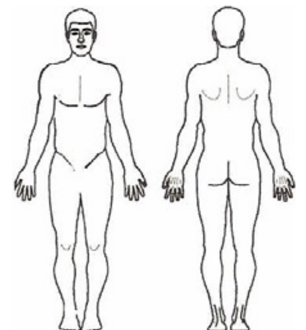
Please briefly describe your areas of complaint ____

How would you rate your pain level?

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain

Mark an ✕ on the picture where you have pain or symptoms →



How often are your symptoms present?

(Occasional) 0-25% 26-50% 51-75% 76-100% (Constant)

Are your symptoms… ☐ Sharp ☐ Dull ☐ Throbbing ☐ Ache ☐ Burning

Since the problem started is it… ☐ About the Same ☐ Getting Better ☐ Getting Worse

What makes it worse? ____________________ What makes it better? ________________________

Does it interfere with… ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Other doctors seen for this problem (please list) ____

List any medications you are now taking: ____

Have you had any surgeries? ____

Did you suffer from any traumas (physical or emotional)? _____________________________________

Have you had any car accidents? ____

Have you had any work injuries? ____

On a scale of 1-10 describe your stress level (1=none/ 10=extreme) ________________________________

On a scale of Poor-Good-Excellent describe your: Diet _______Exercise _______General Health ______

Please check (X) all symptoms or conditions that you have ever had, even if they do not seem related to your current problem.

- ☐ Headache
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Numb Arm/Fingers
- ☐ Numb Leg/Toes
- ☐ Sleeping Problems
- ☐ Diarrhea
- ☐ Cold Sweats
- ☐ Menstrual Pain
- ☐ Visual
- ☐ Disturbances
- ☐ Loss of Smell
- ☐ Recent Fever
- ☐ Pain at Night
- ☐ Depression
- ☐ Abnormal Wt. Gain
- ☐ Constipation
- ☐ Ulcers
- ☐ Heartburn
- ☐ High Blood
- ☐ Pressure
- ☐ Fatigue
- ☐ Ringing in Ears
- ☐ Loss of Taste
- ☐ Nervousness
- ☐ Tension
- ☐ Irritability
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Problem Urinating
- ☐ Osteoporosis
- ☐ Seizure/Epilepsy
- ☐ Dizziness/Fainting
- ☐ Loss of Balance
- ☐ Stomach Upset
- ☐ Cold Feet
- ☐ Hot Flashes
- ☐ Corticosteroids
- ☐ Birth Control Pills
- ☐ Diabetes
- ☐ Stroke
- ☐ Cancer/Tumor
- ☐ Prostate Problems
- ☐ Abnormal Wt. Loss
- ☐ Morning Pain/Stiff
- ☐ Pain Unrelieved by Position or Rest
- ☐ Other__________

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FAMILY HEALTH PROFILE

We are not only interested in your health and well-being, but also your family and loved ones.
Please mention below any health conditions or concerns you may have about your:

Children ____

Spouse/Partner/Significant Other ____

Other Family Members ____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt of said payment. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. The statements on this form are accurate to the best of my knowledge and I agree to allow this office to examine me.

Signature____Date ____________________________