

A Wellness Center
at Little River



Name _____ Preferred Name _____

Address _____

City/State/Zip _____

Phone # (Home) _____ (Cell) _____

Is it okay to contact you at work? No Yes Work # _____

Email Address _____

Birthdate ____/____/____ Age _____

Occupation _____ Employer _____

Marital Status Single Married Separated Divorced Widowed

Spouse's Name _____ Phone# _____

Children's names and ages _____

Do you have any pets? No Yes If yes, please tell us what kind(s) _____

Emergency contact: Name _____

Relationship _____ Phone # _____

Favorite hobbies or interests _____

What Brings You Here?

Have you ever had chiropractic care before? No Yes

If yes, please tell us the doctor's name _____

Were you pleased with your care? No Yes

How did you find out about our office? _____

Is this appointment related to: Wellness Pain Accident
 Nutrition Other _____

When did the incident occur? _____

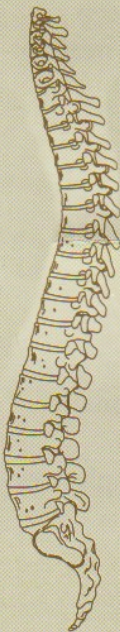
Are you receiving care from other health professionals? No Yes

If yes, please name them and their specialty _____

Please list any drugs or medications you are taking _____

Please list any vitamins/herbs/homeopathics/other you are taking _____

Are you pregnant? No Yes If yes, what month? _____



Healthy History

Do you have, or have had, any of the following (please check all that apply)

- | | | | | |
|------------------------------------|----------------------------------|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> mumps | <input type="checkbox"/> influenza | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> smallpox |
| <input type="checkbox"/> pleurisy | <input type="checkbox"/> polio | <input type="checkbox"/> chickenpox | <input type="checkbox"/> thyroid disease | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> epilepsy | <input type="checkbox"/> cancer | <input type="checkbox"/> depression | <input type="checkbox"/> whooping cough | <input type="checkbox"/> anemia |
| <input type="checkbox"/> eczema | <input type="checkbox"/> measles | <input type="checkbox"/> arthritis | <input type="checkbox"/> heart disease | <input type="checkbox"/> rashes |

If you have ever been diagnosed with another disease or condition, please describe _____

- Do you use
- | | | | |
|----------------------------------|-------------------------------------|--|--------------------------------|
| <input type="checkbox"/> coffee | <input type="checkbox"/> tea | <input type="checkbox"/> artificial sweeteners | <input type="checkbox"/> sugar |
| <input type="checkbox"/> alcohol | <input type="checkbox"/> cigarettes | <input type="checkbox"/> recreational drugs | |

Have you ever suffered from (please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> neck pain | <input type="checkbox"/> stuffy nose | <input type="checkbox"/> discolored urine |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> allergies | <input type="checkbox"/> gas/bloating after meals |
| <input type="checkbox"/> headache | <input type="checkbox"/> fainting | <input type="checkbox"/> heartburn |
| <input type="checkbox"/> migraines | <input type="checkbox"/> weight loss | <input type="checkbox"/> colitis |
| <input type="checkbox"/> arm back/tingling | <input type="checkbox"/> poor appetite | <input type="checkbox"/> irritable bowel |
| <input type="checkbox"/> shoulder pain | <input type="checkbox"/> excessive appetite | <input type="checkbox"/> black or bloody stools |
| <input type="checkbox"/> hand pain/tingling | <input type="checkbox"/> nervousness | <input type="checkbox"/> constipation |
| <input type="checkbox"/> leg pain/tingling | <input type="checkbox"/> confusion | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> jaw pain | <input type="checkbox"/> depression | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> dental problems | <input type="checkbox"/> stroke |
| <input type="checkbox"/> lung problems | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> paralysis |
| <input type="checkbox"/> abnormal blood pressure | <input type="checkbox"/> vomiting | <input type="checkbox"/> numbness |
| <input type="checkbox"/> irregular heartbeat | <input type="checkbox"/> prostate problem | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> ankle swelling | <input type="checkbox"/> breast pain/lump | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> cold extremities | <input type="checkbox"/> cramps | <input type="checkbox"/> loss of sleep |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> painful urination | <input type="checkbox"/> difficulty hearing |
| <input type="checkbox"/> vision problems | <input type="checkbox"/> bladder trouble | <input type="checkbox"/> ear pain |
| <input type="checkbox"/> difficulty breathing | <input type="checkbox"/> excessive urination | |

If applicable, date of last menstrual period _____

Past injuries can affect present health (please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> falls/accidents | <input type="checkbox"/> head injuries | <input type="checkbox"/> fights |
| <input type="checkbox"/> sports injuries | <input type="checkbox"/> broken bones | <input type="checkbox"/> dislocations |
| <input type="checkbox"/> spinal tap | <input type="checkbox"/> surgery | <input type="checkbox"/> traction |
| <input type="checkbox"/> use(d) a cane or walker | <input type="checkbox"/> extensive dental work | <input type="checkbox"/> dental appliances |
| <input type="checkbox"/> knocked unconscious | | |

If yes to any of the above, please describe _____

