Comprehensive Health Profile History

Welcome! As part of your first visit we will be gathering a thorough health history to help me find out what is going on in your body. My job is to help you and today I am going to determine if I can and the best way to serve you. Please do your best to fill this out to the best of your ability, even if you do not feel it is relevant to why you're here. It is my job to understand all past and current stressors that have or currently are affecting you physically, chemically, mentally, emotionally and spiritually. Please know that I value your time and my goal is to provide you with the best possible care. Thank you for choosing Embodied Chiropractic!

Today's Date: _____
Please check your reason(s) for seeking care:
Pain relief_____ Stabilization_____ Family Health/Prevention____ Doctor's Advice____
Personal Data
Name _____ Date of Birth: _____ Gender: M/F
Address_____
Street City State Zip Code

Home Phone#: (_____)_____ Cell Phone#(_____)_____ (Circle preferred)
Email _____ SSN: _____-_____-_____
Height: _____ Weight: _____
Married/Life Partner: Yes No **Significant Other's Name ____**_____
Children('s) Name(s) & Age(s): _____
Emergency Contact: _____ Relationship to you: _____
Address: _____ Phone: _____
Are you currently pregnant? Yes No **If yes, what is your due date? _____**
Whom may we thank for referring you to Embodied Chiropractic? _____

Occupation:_____Employer: _____
Work Phone _____ May we contact you there if needed? Y N
Do you enjoy what you do? Y N **Duties/ Habits**: ____ sit more than 1 hour

_____ repetitively bend or twist _____repetitively type _____ cradle the phone shoulder to ear (side? L or R)

_____ drive on the job (car or other) ___ lift more than 10 lbs repetitively

____ carry equipment/tools on your body (i.e. utility belt, child)

Other Data
Have you ever received Chiropractic Care? Y N With whom? _____

Date of last visit: _____ Why did you stop care? _____

Do you have a family medical doctor? Y N Who? _____

Do you consult them regularly? Y N If so, why? _____

Date of last medical consultation and result: _____

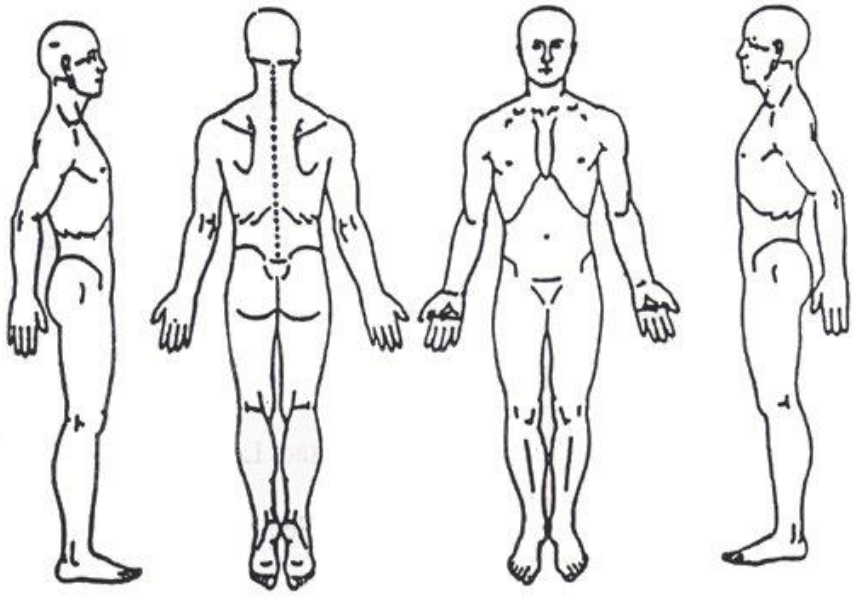
For women: Date of last menstrual period: _____

About Your Health

The human body is designed to be healthy. Throughout life, events occur and our body has two choices: It can either integrate the physical, mental, chemical, emotional or spiritual stress or it can store that experience to be integrated at a later time when the body is willing, ready and able. These stored experiences eventually become symptoms in the body thus giving us a lesser quality of life. This case history will uncover the layers of stored experiences in your body. Following the Chiropractic Exam, you will get an outline of care that will begin to correct these layers and recover your innate health potential!

Current Health Concern

What is the reason for your visit today? _____
Has this ever happened before?_____
When did this first occur? _____
How did it happen? _____
Body diagram: mark where your body is affected



Do you have: (Circle) Pain------Numbness------Tingling
How would you describe the pain? (Circle all that apply)
Dull-------Ache------Sharp------ Burning-----Throbbing-----Constant-----Intermittent

Is there any: (Circle) swelling-----cramping------weakness-------Stiffness

Does this condition/pain travel anywhere else in your body? Y N
If yes, where? _____
Does this affect you more at a certain time of day? Y N
Explain: _____
Is there anything that makes your condition/pain better? Y N
Explain: _____
Is there anything that makes your condition/pain worse? Y N
Explain: _____
Rate the pain when it's at it's worst:
(No complaint/Pain)0 1 2 3 4 5 6 7 8 9 10 (Worst possible complaint/pain)

Have you seen any other health professional or received any advice or treatment for this?
Explain: _____
Have you done anything for this (Including but not limited to ice, heat, rest, massage, diet change, drugs) _____
What else have you tried that did not work? _____
Is this getting worse, better, or staying the same?
Explain: _____
What is this problem interfering with?
Mood/attitude/patience-------relationships & intimacy------activity & play------work-------day-to-day activities------ability to relax------overall quality of life

Are there any other health concerns that you are having that may or may not be related or that are important to you?_____

Developmental History (pre-birth thru age 18)

Your MOM's Pregnancy with YOU: *Check all that apply*
Tobacco____ Alcohol____ Medications_____ Recreational Drugs____ Falls/Injuries_____
Abuse (Physical, sexual or emotional?)____ *Details of any checked?*_____
_____

Your Birth: *check all that apply*
Hospital____ Home____ Vaginal____ Cesarean(Emergency or scheduled)____ Forceps____
Vacuum/Suction____ Induced____ Epidural_____ Complications____
*Details of any Checked?*_____
_____

Your Childhood (0-18): *Check all that apply*
Breast fed____ Formula fed(dairy or soy?)____ Vaccinations (all or modified?)____
Falls/accidents/injuries____ Fractures/Dislocations____ Ear Infections____ Colic____ Asthma____
Surgeries/Hospitalizations____ Abuse____ Special Diet_____ Allergies____
Crawled before Walking____ Abuse(physical, sexual, or emotional?)_____
*Details of any checked:*_____
_____

Adult History: Age 18 to present *Check all that apply*

Please mark any of the following conditions or symptoms that you have now or have experienced: Mark all that apply with (N) for Now, (P) for Past

___ Weight changes
___ Frequent Colds/Flu
___ Fever
___ Asthma/Respiratory disease
___ Sinus problems/Allergies
___ Anemia
___ Skin Conditions
___ Neck/Back pain
___ High cholesterol
___ High blood pressure
___ Heart Attack
___ Stroke
___ Depression
___ Organ removal
___ Bipolar disorder
___ OCD
___ ADHD/ADD
___ SAD
___ Concussion/Head injury
___ Digestive problems
___ Cancer
___ Menstrual problems/ pain
___ Reproductive Organ Disorders
___ Numbness/Tingling
___ Dental/Jaw issues
___ Headaches
___ Diabetes (Type:_____)
___ Arthritis (Type? _____)
___ Bowel/bladder changes
___ Painful Urination
___ Urinary Tract Infections
___ Diarrhea/Constipation
___ Dizziness/Vertigo
___ Ear/Hearing Issues
___ Eye/Vision Issues
___ Thyroid Disorder
___ Ringing in Ears
___ Shortness of Breath
___ Nervousness/Anxiety

Other:_____
Details of Checked: _____
_____
_____

___Tobacco ___Alcohol ___Medications ___Recreational drugs ___Vaccinations ___Falls/injuries ___Accidents ___Surgeries/organs removed ___Dislocations/fractures ___Sports injuries ___Abuse (Physical, sexual, or emotional?)
Details of any checked: _____
_____
_____
___Particular diet (type:_____) ___ Vitamins or supplements (details:_____)
___Regular exercise (frequency?_____ /type?_____)
___Occupational stress ___Mental/emotional stress ___Physical stress ___Chemical stress
Details of any checked: _____
_____
_____
Sleep habits: ___ Hours per night / ___Sound ___Disrupted / ___ Nightmares / ___ Sleep apnea
Details of any checked: _____

Women Only: *Please fill out the following questions regarding your own pregnancies/birth*
Miscarriage or Abortions: Y N Please explain:_____
Are you taking birth control? Y N
Past Deliveries: *(Check regarding most recent delivery; explain all deliveries)*
Third trimester presentation: Vertex_____ Breech_____ Transverse____ Face/Brow____
Type or birth: Vaginal _____ Forceps____ Suction cup/Vacuum____ Cesarean____ Hospital____ Home____
Interventions: Pitocin_____ Epidural_____ Episiotomy_____ Assisted Pushing_____
Delivery Location: _____ OB/Midwife_____

Pregnancy & Birth Story:

_____
_____
_____
_____
_____
_____
_____

Current Pregnancy:

Do you plan on delivering at:(circle) Home Birthing Center Hospital

If not delivering at home, please name birthing location: _____

Do you plan on using a: (circle all that apply) Midwife Doula Nurse Midwife OB

Names:_____

Do you plan on breastfeeding? Yes No

For how long? _____ or why not? _____

Do you plan on vaccinating? Yes No

If yes, what schedule are you choosing: Full Delayed Modified

Why? _____

Signature _____ Date _____

** Remember, health is a process. Past and present choices affect this process. Thank you for taking the time to provide me with the information I need to best help you achieve your health goals. Congratulations on taking an active step toward health and thank you for giving me the opportunity to participate in this process.*

We offer many payment options in an attempt to keep down prices and minimize your time at each visit. Please check which you prefer from each list. This information does not commit you to anything; it serves only to help us assist you better.

Payment Frequency:

___ Pay at each visit
___ Pay ahead with a discount

Type of Payment:

___ Credit or Health Savings Card
___ Check or Cash

If using a Card:

___ Pay in person
___ Auto-pay with a card on file

Participant Consent Form

When a participant seeks chiropractic health care and we accept a participant for such care, it is essential for both to be working toward the same objectives. It is important that each participant understand both the objectives and the methods that will be used to attain said objectives. This will prevent any confusion or disappointment. You have the right, as a participant, to be informed about the condition of your health and the recommended care and management to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic *is a science, art and philosophy that concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health.*

Health *is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. Therefore, symptoms are NOT a valid measure of health.*

Subluxation *is the physical manifestation of an un-integrated life experience. When one or more of the 24 vertebrae of the spinal column are misaligned, the system as a whole is affected: structurally, chemically, and tonally. This results in interferences to nerve system function, leading to tightened muscles and taught ligaments, therefore leading to a decrease in the body's overall, healthy performance.*

Subluxations are corrected and/or reduced by an ***adjustment.*** *An adjustment is the specific application of forces to correct and/or reduce subluxation. Our chiropractic method of correction is by specific adjustments of the spine and related structural components. Adjustments are usually done by hand but may be performed by handheld instruments or specialized tables.*

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I will call the office if I have any questions or if any problems arise before each scheduled follow-up visit. I have read and understand all of the above statements.

_____ _____

Signature *Print Name*

_____

Date