PRACTICE MEMBER HEALTH ASSESSMENT

***Name*____ *Date*___________**
SS#:* _______________ *Date of Birth* ___/___/___ *Age* ___ Y*Male* Y*Female
Y *Single* Y *Married* Y *Coupled* Y *Divorced* Y *Separated* Y *Widowed*
***Address*________________________________ *Town* ____________ *Zip*______**
***Home Phone* (___)____________________ *Work Phone* (___)______________**
***E-mail address* __________________________ *Occupation* ________________**
***REFERRED BY* ____________________ *Primary Physician* _______________**

This form is designed to help us personalize the care you will receive in this office. Our goal is to provide you with the ultimate in wellness based quality-of-life driven Chiropractic care. PLEASE COMPLETE THIS ENTIRE FORM.

***Your Health Goals* (please check all that apply)**
Y *I want to ensure that my body is functioning at its best, so I can live life to the fullest.*
Y *I want Improved physical performance* Y *I want to handle stress better* Y *I want to regain my health*

Your Lifestyle

*** What does your daily physical activity consist of?***
Y *Mostly sitting* Y *Mostly standing* Y *Light manual labor* Y *Moderate manual labor* Y *Heavy labor*

*** Do you exercise? (Check all that apply)* Y *No* Y *1-2 times/week* Y *3-4 times/week* Y *5-7 times/week***
Y *Cardiovascular* Y *Stretching* Y *Weight machines* Y *Free weights* Y *Sports activities*

*** Are there any barriers to maintaining or increasing your exercise level?***
Y *Time* Y *Cost* Y *Lack of facility/equipment* Y *No one to exercise with* Y *Physical incapacity* Y *None*

*** How would you describe your nutritional habits?***
Y *Three square meal/day* Y *Well balanced* Y *I eat when I can* Y *Vegetarian* Y *Junk food*

*** What is your current Stress level?***
Y *No stress* Y *Mild stress* Y *Moderate stress* Y *High stress*

*** What methods do you use to manage your stress?***
Y *Chiropractic* Y *Meditation* Y *Massage* Y *Yoga* Y *Tai chi* Y *Foot Reflexology* Y *Other* __________

*** How has your energy level been lately?***
Y *Extremely energetic* Y *Very energetic* Y *Somewhat energetic* Y *Not very energetic* Y *Lack energy*

*** How would you best describe your predominant mood lately?***
Y *Calm/peaceful* Y *Happy* Y *Excited* Y *Balanced* Y *Tense or anxious* Y *Blue & down* Y *Angry or upset*

*** Which quality would best describe you? (Choose only one)* Y *Assertive* Y *Compliant* Y *Withdrawn***
*** What is your GREATEST motivator? (Chose only one)* Y *Fear* Y *Anger* Y *Image***

*** Have you had a significant weight gain or loss in the past year?* Y *No* Y *Yes: How Much?* ______**
*** Do you take nutritional supplements?* Y *Yes* Y *No***
*** Is your mattress comfortable?* Y *Yes* Y *No: How old is it?* ______**
*** Do you wear:* Y *Heel lifts* Y *Inner soles* Y *Arch supports* Y *TMJ appliance* Y *Supports or Braces***
*** Tobacco use:* Y *Past* Y *Present ~* Y *Occasional* Y *Moderate* Y *Heavy***
*** Caffeine use: (coffee, tea, soft drinks)* Y *Past* Y *Present ~* Y *Occasional* Y *Moderate* Y *Heavy***

* Primary Health Concern____

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* Date of Onset ________________ What kind of onset did you experience? Y Gradual Y Sudden
* How did it begin? YSports injury YAuto collision YWork injury Y Housework YOther____________

* How would you describe the sensation? (check all that apply)

YSharp YDull Ache YIntense Ache YBurning YThrobbing YTingling
YShooting YSpasm YNumbness YWeakness YStiffness Y Other________

* How often is the sensation present?

Y Constant (80-100%) Y Frequent (50-80%) Y Occasional (25-50%) Y Intermittent (<25%)

*How would you rate the intensity? (Circle the appropriate number)

0 1 2 3 4 5 6 7 8 9 10

(no discomfort) (Moderate Discomfort) (Unbearable)

* Since the problem began, is your complaint: Y better Y same Y worse

* What gives you relief?

YNothing YWalking YStanding YSitting YMoving around/exercise YLying down YRest

* What aggravates your complaint?

Y Nothing Y Walking Y Standing YSitting YMoving around/exercise YLying down YRest

* Is your complaint affecting your ability to work or do other routine daily activities?

Y No effect Y Have some limited physical restrictions, but can function Y Need some assistance with daily activities YCannot function without assistance Y Cannot work Y Totally disabled

* What important things does it prevent you from doing? ________________________________
* Have you had this complaint before? YYes Y No When? ____________________________
* Have you seen a physician for this complaint? YYes YNo Name________________________

PAST AND PRESENT CONDITIONS

	Past	Present		Past	Present
Headaches……………..	Y	Y	Uterine or ovarian condition………….	Y	Y
Dizziness………………	Y	Y	Prostate condition………………………..	Y	Y
Fainting spells………..	Y	Y	Diabetes…………………………………..	Y	Y
Convulsions…………..	Y	Y	Arthritis……………………………………	Y	Y
General fatigue……….	Y	Y	Skin condition……………………………	Y	Y
High blood pressure…	Y	Y	Stroke……………………………………..	Y	Y
Heart condition………	Y	Y	Cancer…………………………………….	Y	Y
Respiratory condition.	Y	Y	Allergies/asthma……………………….	Y	Y
Digestive problems….	Y	Y	Sinus conditions………………………..	Y	Y
Menstrual problems…	Y	Y	Kidney/bladder…………………………..	Y	Y

Other conditions: ____

* Family Health History: Father____________ Mother____________ Siblings_________________
* Women: Number of pregnancies: __ Number of children: __ Are you pregnant? YYes YNo
* List all surgeries and dates: ____
* Have you had any recent spinal x-rays or other tests? YYes YNo Dates: ________________
* Have you had any serious motor vehicle or other accidents: YYes YNo
If yes, please explain____
* List any medications that you're currently taking: ______________________________________

Signature Date