

Welcome to Picture of Health Family Chiropractic! Please take a few moments to answer the following questions so that I can get a well-rounded picture of your overall health, and therefore serve you to my greatest ability.

Name _____ Date of Visit _____
Address _____ City/State/Zip _____
Home Phone _____ Work/Cell Phone _____ Birth date _____
Occupation _____ Insurance? _____ Name of Company _____
Physician or Primary Health Care Provider(s) _____

Reason for today's visit: _____

Do you currently, or have you any history of cancer, stroke, cardiovascular disease, or diabetes? _____

Significant family history (cancer, cardiovascular disease, diabetes, stroke, etc.) _____

Please mark areas where your body has felt or is currently feeling a lack of ease or discomfort.

head face neck chest shoulders arms
 sternum rib cage abdomen elbows wrists fingers
 upper back mid back low back buttocks tail bone legs
 feet toes knees breathing sacrum clavicle
 heart lungs ankles eyes hips hands

Please mark areas where you have experienced problems:

thyroid nervousness sweating headaches allergies digestion
 circulation depression memory vision prostate circulation
 fatigue anxiety/panic speech eyes urinary appetite
 constipation blood pressure breathing sleep weight diarrhea
 blood clots tasting stress hearing asthma incontinence
 smelling spine gas tumors organs dizziness
 fainting varicose veins sciatica weakness sinuses other

IMMUNE SYSTEM

In general, how do you tend to heal? slowly average quickly

How many colds/flu's do you experience each year? _____

When do you have a cold/flu, how many days do they last? _____

How do you take care of yourself when you don't feel well? _____

Are you currently experiencing, or have you in the past experienced any immune system disorders? (e.g. Epstein-Barre, Thyroid issues, Lupus, HIV, etc) _____

NERVOUS SYSTEM

Are you currently, or have you in the past had problems with any of the following?

dizziness radiating pain panic attacks/ walking
 tingling muscle spasms anxiety falling down
 tremors numbness muscle weakness other
 coordination balance nervousness

REPRODUCTIVE SYSTEM

Women:

Are you pregnant? _____ If so, due date _____

Where do you plan to give birth? home birth center hospital other
How many children do you have? _____ # of pregnancies _____ Are you on birth control? _____
Do you experience any menstrual problems/irregularities? _____
Any breast changes/concerns? _____
Are you going through, or have you gone through menopause? _____ Any concerns? _____
Have you had a hysterectomy? _____ If so, when? _____ Hormone replacement therapy? _____
Do you have any other reproductive concerns? _____

Men:

Are you noticing any changes in your reproductive system that are causing you concern? _____
Any urinary problems/changes/difficulty? _____
When was your last physical exam? _____

ACCIDENTS/TRAUMA

List any accidents, falls, athletic injuries, and other physical traumas: _____

Have you ever been admitted into a hospital? _____ If so, why? _____

Do you know anything about your birth process? yes no

Please answer the following according to your comfort level:

Have you experienced any emotional trauma from which you have not yet recovered? yes no
Have you ever experienced any form of abuse? yes no

LIFESTYLE

What do you do to take time for yourself, that brings you joy and/or feeds your soul? _____

Do you participate in yoga, meditation, or any other spiritual practice? yes no If so, please describe _____

Do you participate in any exercise or sports? _____

How would you describe yourself in the following areas?

Emotional health _____

Physical health _____

Mental health _____

Overall quality of life _____

Mark all health care treatments you have utilized:

chiropractic homeopathy herbs
massage acupuncture colonics
other forms of bodywork acupressure other _____

When you are not feeling well, your first choice of health care is: holistic medical other

List all medications (prescription and over the counter) you are currently taking: _____

List all vitamins, herbs, and/or supplements you are currently taking: _____

Mark all of the following that you use regularly:

alcohol recreational drugs caffeine
tobacco soft drinks aspartame (nutrisweet)