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) _____ Email address _____
How did you hear about us? _____
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/flues 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)