



Shoreline Family Chiropractic & Wellness
Confidential Patient Health Profile

Date: ___/___/___ Whom may we thank for referring you? _____

Patient Name _____ SSN _____

Address _____

Birth date _____ Age _____ Marital Status M S D W City _____ State _____ Zip _____

Home Phone (____) _____ Email address _____

Work Phone (____) _____ Occupation _____

Cell Phone (____) _____ Employer _____

Spouse's Name _____ Occupation _____

Name of primary care physician _____

The human body is designed to be healthy. As Chiropractors, we focus on your ability to express optimal health. Our goals are first, to address the issues that brought you into our office and second, to offer you the opportunity to achieve your true health potential. The following answers you provide will help us determine whether or not Chiropractic care can be beneficial in helping you achieve your desired goals from our office.

PRESENT HEALTH STATUS & GOALS

1. What are your objectives at our office: _____

2. Assuming that we can help you, how would you like us to address your health?
_____ Symptom Relief Only (Does not correct the cause of the problem)
_____ Maximum Correction (Corrects the cause of the problem, leading to wellness care)

3. What is your health philosophy? (What should you be doing to be healthy?) _____

4. What are your favorite hobbies, activities, and sports in which you participate? _____

5. Are your current health concerns affecting these activities? _____ Yes _____ No

6. Have you ever had your spine & nervous system examined professionally? _____ Yes _____ No
If Yes, by whom & when _____

7. Have you ever received spinal adjustments by a Doctor of Chiropractic? _____ Yes _____ No
If Yes, by whom & when _____
How long were you receiving adjustments for? _____ How often? _____
Why did you stop going? _____

8. Does your immediate family receive Chiropractic Care? _____ Yes _____ No

Chiropractic is the detection and correction of Vertebral Subluxations (spinal dysfunction that cause disruption to your nervous system) to maintain proper health. Subluxations are caused by physical, chemical, and emotional stressors to the body. Please complete the section below so that we may have a better understanding of your health status and the stress that your body has previously had or currently is experiencing.

1. I currently exercise _____ daily _____ weekly _____ monthly _____ never
2. I currently wear _____ foot orthotics _____ heel lifts
3. Age of mattress _____ Is it comfortable? _____
4. Have you had any impacts, falls, sports injuries, etc. that you feel specifically injured your spine or nervous system? _____ Yes _____ No Explain: _____

5. Have you been involved in any previous motor vehicle or work-related injuries?
_____ Yes _____ No Explain: _____

6. In the past 12 months I have experienced the following ___ Headaches ___ Fatigue ___ Pain/ Tension ___ Digestive Problems ___ Allergies/Sinuses ___ Moodiness/ Irritability ___ Nervousness ___ Asthma ___ Weight trouble ___ Dizziness ___ Sleep Problems/ Insomnia ___ Bladder Trouble ___ Other

7. Have any of these health problems caused ___ Moodiness ___ Irritability ___ Interrupted Sleep ___ Less Productive ___ Exhausted ___ Unable to Perform Job or Hobby ___ Other _____

8. Have you ever been hospitalized? _____ Yes _____ No Explain: _____

9. Have you had surgery? _____ Yes _____ No Explain: _____

10. Are you currently taking any medications (list the drug and reason for taking)? _____

How would you grade your physical health? _____ Excellent _____ Good _____ Fair _____ Poor
How would you grade your emotional health? _____ Excellent _____ Good _____ Fair _____ Poor
I feel that over the past 5 years, my health has: _____ Improved _____ Same _____ gotten worse

11. Do you: Smoke _____ Drink Alcohol _____ Use Drugs _____ Have excessive stress _____

12. I have a family history of: Heart Dz _____ Stroke _____ Cancer _____ Diabetes _____ Other _____

13. I remember important things in my life by what: _____ I see _____ I hear _____ I feel

14. On a scale of 1-10 (10 being most) how committed are you to maximizing your health potential? _____

15. What is the name of your insurance company? _____

I certify that the above information is correct to the best of my knowledge. If at any point, any of the previous information changes, I shall notify this office immediately with the correct information.

PATIENT'S SIGNATURE: _____ DATE: _____

SIGNATURE OF GUARDIAN, IF PATIENT IS UNER 18: _____