

Name: _____ Age: _____ Date: _____
 Address: _____
 Primary Phone Number: _____ Secondary Phone Number: _____
 E-Mail Address _____ Male _____ Female _____
 Social Security # _____ (or) Driver's License # _____ Birthday _____
 Occupation/Employer's Name _____
 Single _____ Married _____ Divorced _____ Widowed _____ Spouse's Occupation/Employer _____
 No. of children (and ages) _____
 We love referrals! Who may we thank for referring you to our office? _____
 How did you find us? Internet _____ Facebook _____ Community Event _____

Your Health Profile

How This Form Will Help You!

As a full spectrum Chiropractic office, we focus on your body's ability to HEAL. We want to help you first, by addressing the issues that brought you to this office, and second, offering you the opportunity of improved health potential and wellness services in the future. On a daily basis, we experience physical, chemical and emotional stresses that can accumulate and result in *serious loss of health* potential. Most times the effects are gradual: not even felt until they become serious. When you answer the following questions, they give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

The Beginning Years (to Age 17)

New research studies are showing that many of the health challenges that present/manifest later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Your Childhood Years

	Yes	No	Unsure		Yes	No	Unsure
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was there any prolonged use of medicine such as antibiotics or inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any childhood illness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you suffer any other traumas? (physical or emotional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	As a child, were you under regular chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any serious falls?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you take/use drugs/alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adult – (18 to Present)

	Yes	No		Yes	No
Do / Did you smoke? # _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant? Due _____	<input type="checkbox"/>	<input type="checkbox"/>
Do / Did you drink alcohol? # _____	<input type="checkbox"/>	<input type="checkbox"/>	Do / Did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>
Do / Did you drink caffeine? # _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had surgery? Please list dates and describe: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	Any accidents/injuries? Please list dates and describe: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>

On a scale of 1-10 describe your stress level (1=None / 10=Extreme) Occupational _____ Personal _____

On a scale of 1-10 (1=Poor / 10=Excellent) describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here _____ **“Wish to have Chiropractic Wellness Services”** and skip to **“Family Health Profile.”**

All others need to answer the following questions...

Area of Complaint: _____ Right Left Front Back

Date of Onset: _____

If you are experiencing symptoms, is it... Sharp Dull Comes and goes Travels Constant

Since the problem started, is it... About the same Getting better Getting worse

What makes it better? _____

What makes it worse? _____

Yes, it interferes with: Work Sleep Walking Sitting Hobbies Leisure

When do the symptoms occur? Morning Afternoon Evening Constant Comes and goes

Other Doctors seen for this problem (please list)

Chiropractor _____ Last Visit Date? _____

Medical Doctor _____ Last Visit Date? _____

Medications _____

Other _____

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

<input type="checkbox"/> Headaches	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Cold Sweats
<input type="checkbox"/> Pins and Needles in Arms	<input type="checkbox"/> Tension	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Cold Feet
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/> Stomach Upset	<input type="checkbox"/> Cold Hands
<input type="checkbox"/> Numbness in Fingers	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Buzzing in Ears	<input type="checkbox"/> Loss of Smell
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Pins and Needles in Legs	<input type="checkbox"/> Lights Bother Eyes	<input type="checkbox"/> Loss of Taste
<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Numbness in Toes	<input type="checkbox"/> PMS	<input type="checkbox"/> Sleeping Problems
<input type="checkbox"/> Neck Stiff	<input type="checkbox"/> Constipation	<input type="checkbox"/> Menstrual Irregularity	<input type="checkbox"/> Depression
<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Problem Urinating	<input type="checkbox"/> Fainting	<input type="checkbox"/> Irritability

List **all medications** you are taking _____

Family Health History Profile

Please list any health conditions or concerns in your immediate family:

Examples: Cancer / Diabetes / Allergies / Asthma / Ear Infections / Arthritis / Scoliosis / Eyesight / Headaches / Cholesterol / High Blood Pressure / Stroke / Alzheimer's / Parkinson's / Poor Posture / Ect.

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

At our office we are not only interested in your health and well-being,
but also the health and well-being of your family and loved ones.

Tell Us About Your Health and Lifestyle Choices

Do you:

Use Vitamins? Yes No

If yes; are they Whole Food Synthetic Unsure

Please list: _____

Watch more than 5 hours of TV a week? Yes No

Spend 5 or more hours on a computer daily? Yes No

Drink Soda? Yes No Diet Regular

Are you a member of a health club/gym? Yes No

What do you do for stress relief? _____

Examples: Exercise / Yoga / Pets / Church / Counseling / Walking / Ect.

Please mark an "X" where you believe your health is and an "O" where you would like to be.



“Chiropractic is health insurance. Premiums small. Dividends large.”

- BJ Palmer

HIPAA and Payment Policy

The Practice’s Privacy Notice are available in the reception area and adjusting rooms. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (“PHI”) necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. All patients have a right to obtain a copy of the Privacy Notice prior to signing this Consent.

I understand that, and consent to, the following appointment reminders or communications that will be used by the Practice:

a) A postcard mailed to me at the address provided by me; and

b) Telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

- Insurance
 - Some insurance plans are accepted in our office. Since there are so many plans and coverage varies widely, please call us to find out if your plan covers care in our office.
- No or little chiropractic insurance
 - For patients who have little or no chiropractic insurance coverage, flexible payment programs can be arranged. If you have no insurance or do not have chiropractic benefits there is still a way for you to receive the care you need. Many patients pay directly for care, as they discover chiropractic to be extremely cost-effective and affordable.
- Family Plans
 - Our focus at Health Link Family Chiropractic: A Creating Wellness Center is to actively help you and your family in taking responsibility for your health and wellness. We assist and guide you to take the time to care for the most important people in your world: you and your family. In an effort to make living the wellness lifestyle as easy and affordable as possible, we can create a customized family plan that is specific to you and your family’s needs.
- Payment Policy
 - Copayments are due at the time of service, unless other arrangements have been made. All delinquent accounts past 30 days, will be charged for collection on the account and interest will accrue at 1.5% a month. If an account is delinquent over 30 days the account may be turned over for collections. The responsible party will be responsible for collection agency fees, court cost and attorney fees up to 33 1/3%.

Signature of Patient (or Parent/Guardian)

Date