PERSONAL INFORMATION

Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

Phone # (Home or Work): (____) _____-_____ Cell Phone #: (____) _____-_____

Email: _____ Sex: _____ Age:_____

Marital Status: Single__ Married__ Divorced__ Widowed__ Spouse:_____

Number of Children/Ages? _____ Emergency Contact: _____

Occupation? _____Employer? _____

Whom may we thank for referring you to Health Edge Family Spinal Care?

_____

YOUR HEALTH

What brings you into the office?

- ☐ I have no complaints. I am here for a wellness checkup.
- ☐ Please briefly describe your current health concerns.

_____

_____

_____

When did this problem start? Was there an injury? _____

_____

Is the pain constant or intermittent? _____

Rate the severity of your pain. (1= mild 10= worst imaginable) _____

Since the problem started, it has… _____ Stayed the Same _____ Gotten Better _____ Gotten Worse

Does anything help alleviate the pain? If so please explain. _____

_____

Does this interfere with your: _____Work _____Leisure _____Sleep _____Sports _____Other

Have you seen other doctors for this condition? _____ Chiropractor _____ MD

_____Naturopath _____ Other

Name of Practitioner? _____ What was the diagnosis? _____

What results would you want for yourself?

- ☐ **Reduce pain**
- ☐ **Restore health**
- ☐ **Maintain health**

GENERAL HISTORY

Please list all medications (both prescription and non-prescription) you are currently taking and why:

_____

_____

Have you had any surgeries or hospitalizations? _____

_____

Have you ever experienced any work related injuries? _____

Have you ever experienced any falls or auto accidents? _____

Have you ever experienced any sports related injuries? _____

On a scale of 1-10 (1 being very poor and 10 being excellent) rate your:

Eating habits: _____ Sleep_____ Mind-set:_____

Exercise habits: _____ General Health_____

If there is a need for dietary changes would you like to know? YES NO

If there is a need for specific exercises would you like to know? YES NO

If there is a need for support in the psychological/mind/body/stress Dimension of health would you like assistance? YES NO

Please circle all symptoms you have ever had, even if they do not seem related to your current problem:

Headaches/Migraines	Sleeping problem	Facial pain	Ringing/Buzzing in ears
Fogginess/Poor Mental Clarity	High blood pressure	Loss of balance	Tremors
Numbness/Pins and Needles	Asthma	Acid reflux	Allergies/Sinus troubles
Loss of smell/Taste	Menstrual irregularities/Pain	Constipation	Diarrhea
Emotional stress/Anxiety	Frequent colds/Flues	Neck pain + Stiffness	Sciatica
Vertigo/Dizziness/Fainting	Hip/Leg pain	Low back pain + Stiffness	Scoliosis
Fatigue/Low energy	Upper back tension	Hot flashes	Bladder problems

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature:_____ Date: _____

Thank you for filling out this form and taking your first step towards Wellness!