Lighthouse chiropractic

PERSONAL HEALTH PROFILE

Name:	Date:	MSP#
Home Address:	City:	Postal Code:
E-mail Address:	Home Phone: ( )	Work Phone: ( )
Gender: ❐ M ❐ F	Marital Status: ❐Single ❐Married ❐Divorced ❐Widowed	( )

Date of Birth: MM DD YY	Age:	Occupation:	Employer:
Work address:		City:	Postal Code:

How were you referred to our office?	Have you ever received chiropractic care before? ❐ No ❐ Yes Date of last visit? Years of Care? Doctor's Name:
Person to contact in an emergency:	Phone: ( )

Do you have children? ❐ No ❐ Yes	What are your children's names/ages?	If under 18, what are your Parents' names?

Present state of health

Years of continuing damage show up as acute or chronic symptoms.

Is this visit for a wellness checkup? ❐yes ❐no . If this is for a specific concern, proceed below:

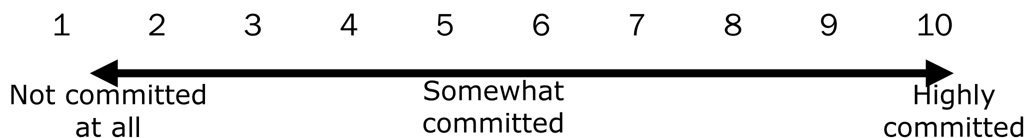
	Primary concern	Secondary concern
Specific concern(s) and location		
How long have you had this?		
How would you describe the pain?	❐ sharp ❐ dull/achy ❐ burn ❐ pins/needles	❐ sharp ❐ dull/achy ❐ burn ❐ pins/needles
How often does this happen?	❐ constant ❐ on/off ❐ daily	❐ constant ❐ on/off
What makes it worse? (sitting, standing etc)		
What have you tried to address this concern?		
At its worst, this problem interferes with:	❐ ability to work ❐ hobbies/sports ❐ family/social time ❐ sleep ❐ daily activities	❐ ability to work ❐ hobbies/sports ❐ family/social time ❐ sleep ❐ daily activities

Do you think your problem will get worse in the next ❒ 1 year ❒ 2 years ❒ 5 years?

Besides the above concern, what is your main reason for wanting to get better/be healthy?
(e.g. exercise, family, job live longer, live easier)

____

On a scale of 1 to 10 (10 being the highest), rate your commitment to improving your health *(circle number):*



Some impacts may even begin at birth and caused damage your nervous system, do your best to recall if;

Birth, Growth and development
You've been a victim of birth trauma like:
❒ long and/or difficult ❒ forceps ❒ vacuum extraction ❒ caesarean ❒ breech ❒ epidural ❒ induced ❒ Natural (no drugs or pulling/excessive force) ❒ don't know?

Did you get checked regularly by a chiropractor as a child? ❒ yes ❒ no

Traumas and stresses

In your life, what were your 5 most serious physical traumas/stresses (eg. automobile jarring/impacts, work stress, recreational activities, sports, falls, fractures) that you can remember.

Trauma	Date of trauma	Office use
1)		
2)		
3)		
4)		
5)		
6)		
7)		

Lighthouse chiropractic

Mental/Emotional stress levels (1 → 10): ______

Stress caused by ❐ work ❐ home ❐ family ❐ other ______________

Have you ever been hospitalized? If so, please describe ____________________________________

What surgeries have you had? ____

What medications are you currently taking?____

What medications have you taken in the last 5 years?_______________________________________

Check off: **Any of the following symptoms you that apply to you.**
Circle: **If you have experienced them in the past.**

- ❐ Tension/Headaches
- ❐ Mid Back Pain
- ❐ Neck Pain
- ❐ Tension Across Top of Shoulders
- ❐ Pain Between Shoulders
- ❐ Numbing/Tingling in Arms/Hands
- ❐ Wrist/Hand pain
- ❐ Chest Pain
- ❐ Heartburn
- ❐ High/Low Blood Pressure
- ❐ Elevated cholesterol
- ❐ Poor Posture
- ❐ Dizziness
- ❐ Blurred/Failing Vision
- ❐ Deafness/Ears Ringing
- ❐ Earaches/Ear infections
- ❐ Low Back Pain
- ❐ Numbing/Tingling in Legs/Feet
- ❐ Hip Pain
- ❐ Iliotibial Band Syndrome
- ❐ Knee Pain
- ❐ Foot Pain
- ❐ Shin Splints
- ❐ Arthritis/Swollen Joints
- ❐ Allergies / Infections
- ❐ Digestive Problems
- ❐ Ulcer
- ❐ Diabetes
- ❐ Bladder Problems
- ❐ Thyroid Problems
- ❐ Weight Trouble
- ❐ Breathing Problems
- ❐ Asthma
- ❐ Immune Problems
- ❐ Frequent Colds/Flu
- ❐ Heart Problems
- ❐ Difficulty Sleeping
- ❐ Anxiety/Depression
- ❐ Poor Concentration/Memory
- ❐ Sexual Dysfunction
- ❐ Infertility
- ❐ Cancer (type: _______)

Other Health Concerns:

____

Women Only:

- ❐ Currently Pregnant
- ❐ Hot Flashes
- ❐ Irregular Cycle
- ❐ Excessive Menstruation
- ❐ Excessive Cramping/Pain
- ❐ Breast Pain/Lumps
- ❐ Date of last menstrual period:___ /___ /___