Compass Chiropractic: Health Profile

Please fill out this form to the best of your ability. All of your information is strictly confidential.

Legal Name: _____ Date: _____

Mailing Address: _____ Occupation: _____

_____ (If retired/unemployed, list former occupation)

Email: _____ Height: _____

Weight: _____lbs

How did you hear about our office? _____

Have you been to a chiropractor before? ❑ Yes ❑ No

If Yes, was it a good experience? ❑ Yes ❑ No Dr._____ Last visit: _____

Are you nervous about being adjusted? ❑ Yes ❑ No

1. Lifestyle:

Smoking: ❑ 0 Cigarettes/day (non-smoker) ❑ 1-3 Cigarettes/day
❑ 0 Cigarettes/day (former-smoker) ❑ 1-2packs/day ❑ 2+ packs/day

Alcohol: ❑ Abstainer (none at all) ❑ Heavy drinker
❑ Light/Moderate drinker ❑ Former Alcoholic (sober since: _____)

Activity Level: ❑ Sedentary (none) ❑ Moderate activity (jogging)
❑ Light activity (i.e. walking) ❑ Vigorous activity (max exertion)

Any hobbies/sports you participate in regularly? _____

_____

2. Medical History:

Hospitalizations/Surgeries: please check the boxes if you have had any of these particular surgeries.

❑ Spine ❑ Shoulder (R/L) ❑ Brain ❑ Lung ❑ Gallbladder
❑ Hip (R/L) ❑ Knee (R/L) ❑ Heart ❑ Breast ❑ Appendix

Year: _____ Area/reason: _____ Procedure: _____
Year: _____ Area/reason: _____ Procedure: _____
Year: _____ Area/reason: _____ Procedure: _____

Prior Accidents/Injuries: includes car accidents, falls, sports injuries, etc.

Year: _____ Area injured: _____ How? _____
Year: _____ Area injured: _____ How? _____
Year: _____ Area injured: _____ How? _____

Ongoing Condition(s)? ❑ No ❑ Yes, please list: _____

Allergies? ❑ No ❑ Yes, please list: _____

Prescription Medications: If you have a medication list, please give us a copy and skip this section.

Medication	Reason	Date Started

Family History: this pertains to siblings, parents, and grandparents **only**

❑ Cancer ❑ Stroke ❑ Arthritis ❑ Seizures ❑ Diabetes
❑ Thyroid ❑ Heart Attack ❑ Osteoporosis ❑ Blood clots ❑ Kidney Disease
❑ Other: _____

Were there any deaths directly related to the above conditions? ❑ No ❑ Yes (fill in below)

Who _____ Condition _____ Age _____
Who _____ Condition _____ Age _____

Review of Systems: have **you** had a problem, whether now or in the past, with any of the following?

❑ Cancer
❑ Stroke/TIA
❑ Diabetes
❑ Hot/Cold Intolerance

❑ Seizures
❑ Double vision
❑ Sleeping problems
❑ Thyroid disorders

❑ Vertigo
❑ Dizziness
❑ Ringing in ears
❑ Ear Infections

❑ Heart attack/disease
❑ Blood clots/DVT
❑ Arrhythmias/Palpitations
❑ Heartburn/Gastric reflux

❑ Jaw pain
❑ Difficulty swallowing
❑ Asthma
❑ Allergies

❑ Osteoporosis
❑ Joint pain
❑ Fatigue
❑ Muscle weakness

❑ Excessive thirst
❑ Inability to hold urine/feces
❑ Constipation/Irritable Bowel

❑ Frequent urination
❑ Weak urine flow
❑ Bloating/Indigestion

❑ Burning/painful urination
❑ Difficulty controlling urination
❑ Food Sensitivity (Gluten, Dairy, etc.)

Other Medical History:

Any steroid/epidural injections? ❑ No ❑ Yes, part of body: _____ Date: _____

Recent infections/immunizations? ❑ No ❑ Yes, please list: _____

Recent unintentional weight loss? ❑ No ❑ Yes, I've lost about _____ pounds in the last _____

FEMALES ONLY: is there any possibility that you are pregnant? ❑ No ❑ Yes ❑ Unsure

3. Primary Complaint: Please fill out this section in regards to your primary complaint only. If you have other health concerns, the doctor will discuss them with you in person.

Briefly describe the main reason you are here: _____

_____

When did this start? _____ ❑ Started suddenly ❑ Started gradually

The problem is: ❑ Right-sided ❑ Left-sided ❑ Both sides ❑ N/A

The problem is: ❑ Constant ❑ Frequent ❑ On and off ❑ Occasional

Grade your pain at this very moment from 1-100, with 100 being the worst: _____ /100

Describe how it feels: ❑ Pain ❑ Stiffness ❑ Weakness ❑ Numbness ❑ Tingling

Check all that apply: ❑ Aching ❑ Burning ❑ Dull ❑ Sharp ❑ Stabbing

Please check off all boxes that apply to this problem

This problem is made worse by:		This problem is usually relieved by:	
❑ Activity	❑ Ice	❑ Cold	❑ Stretching
❑ Bending	❑ Job	❑ Heat	❑ Support brace
❑ Lifting	❑ Kneeling	❑ Activity	❑ Chiropractic
❑ Standing	❑ Lying down	❑ Lying down	❑ Massage
❑ Stress	❑ Morning	❑ OTC medication	❑ Morning
❑ Temp change	❑ Night	❑ Postural change	❑ Night
❑ Twisting	❑ Sitting	❑ Rx medication	❑ Nothing
❑ Arising from chair	❑ Touch/Pressure	❑ Rest	❑ Standing

When present, how long does it last? ❑ Always ❑ Days ❑ Hours ❑ Minutes ❑ Seconds ❑ No pattern

Overall, this problem has been: ❑ Improving ❑ Staying the same ❑ Worsening

Do any of these apply to your job? ❑ Prolonged standing ❑ Prolonged sitting ❑ Heavy lifting

- do you think your job contributed to this problem? ❑ Yes ❑ No

Did we miss something? Please indicate if there is anything else you would like us to know about this problem.

_____

_____

4. Other:

If the doctor suggests home stretches or exercises, would you do them? ❑ Yes ❑ No ❑ It depends

What are your expectations/goals? _____

Emergency Contact: Name: _____ Relationship: _____ Phone: _____

Primary Care Physician: Dr._____ Office Name: _____

Last Visit: _____ Town: _____

I have read and completed the above information and certify it to be true to the best of my knowledge. I hereby permit this office to use my responses to provide me with chiropractic care, according to the state's regulations.

Patient Name (printed): _____

Signature of Patient/Guardian: _____ Date: _____