

COMPREHENSIVE HEALTH PROFILE

PATIENT DATA:

Name _____ Date _____

MEDICAL HISTORY:

Chief Complaint _____

When did this begin?: _____

Have you done anything about this or gotten any advice or treatment? NO - YES

If Yes, what were you told? _____

What was done? _____

Did it seem to work? _____

What was different about you after treatment? _____

What was different about your condition after treatment? _____

What was different about your concern about the condition after treatment? _____

Date of last physical exam: _____

Have you every injured your spine? (neck, head, back, hips?) NO - YES

Date of most significant injury _____

What happened? _____

Date of most recent injury _____

What happened? _____

Have you ever:	NO	YES	Briefly Explain:
Broken bones?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been Hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been in an Auto Accident?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had Sprains / Strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you had X-rays, CAT Scans, or an MRI performed?: _____ If yes, Where? _____

Please list any medications you are taking, also include any supplements or herbs _____

FOR WOMEN:

	NO	YES	
Are you using Birth Control?	<input type="checkbox"/>	<input type="checkbox"/>	What method? _____
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	How many weeks? _____
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>	Any problems? _____
Is your cycle normal?	<input type="checkbox"/>	<input type="checkbox"/>	If no, explain _____

CHIROPRACTIC HISTORY:

Has your spine ever been professionally adjusted? NO - YES

Name of Chiropractor _____ Date of your last visit? _____

Do you sometimes self manipulate your neck? NO - YES

Does your family receive chiropractic care? NO - YES