Welcome to Chiropractic Alchemy!

Please take your time and fill out the following form to the best of your ability in order to help guide your treatment here at our center

Date: _____ / _____ / _____

Name:_____ Address:_____
City: _____ State: _____ Zip: _____

Occupation: _____ Employer's address:_____

Home Phone: _____ Business Phone: _____
Cell Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Sex: M F
Social security number: _____ Marital Status: S M W D Number of Children: _____
Emergency contact: _____ Phone number of emergency contact: _____

Who referred you and/or how did you hear about our office and the services we offer?

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HISTORY

1) List chief health concerns Date of onset How began?
1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____

2) Have you done anything or sought treatment for this situation or concern? □Yes □No

What was done? _____
Did it seem to work? _____

3) What activities, if any, does your current concern slow, hinder or stop you from doing? (circle)

Work Family Personal relationships Hobbies Life enjoyment Relaxation Other:_____

4) What triggers your symptoms? (circle)

Movements Environmental factors Foods Emotions Other:_____

5) What habits have you changed, if any, since having this concern?

_____

6) What concerns you about your symptoms? _____

7) If you didn't have this symptom what would be different in your life?

_____

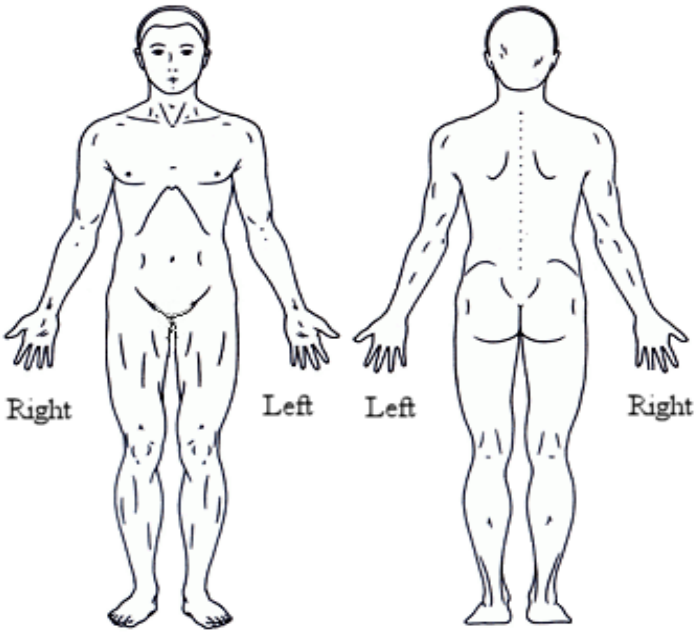
GENERAL INJURY HISTORY

GENERAL PHYSICAL TRAUMA:

1) Have you ever had a head injury? □Yes □No How/When?_____
2) Have you ever broken any bones? □Yes □No Which Ones?_____
3) Have you ever had any impacts, falls, accidents or jolts that you feel specifically may have injured your spine? □Yes □No How / When?_____
4) Have you ever had any x-rays/CT scans/MRIs completed? If so, when and where are they now?
_____

Please mark on the diagram all the places in your body that you have ever been injured. (Examples include falls, broken bones, sprains/strains, scars, etc.)

Please also mark any areas of effected by diseases or that may have been diagnosed by a doctor. (Examples include heart disease, cancer, stroke, multiple sclerosis, etc.)



PAST MEDICAL HISTORY:

Please list any past medical history including surgeries, procedures, and medical diagnoses:
_____
_____

FAMILY MEDICAL HISTORY:

Please list any pertinent family history:
_____
_____

NERVOUS SYSTEM	MUSCLES & JOINTS	CARDIO-VASCULAR	RESPIRATORY
__ Convulsions/seizures __ Clumsiness __ Dizziness __ Easily fatigued __ Fainting __ Loss of balance __ Loss of coordination __ Headache __ Migraine __ Memory loss __ Nervousness __ Numbness __Shaking/Tremors	__ Low Back Problems __ Pain between Shoulders __ Neck Problems __ Arm Problems __ Leg Problems __ Swollen Joints __ Painful Joints __ Stiff Joints __ Sore Muscles __ Weak Muscles __ Muscle cramps __ Muscle twitching __ Walking problems __ Heavy limbs __ Sprains/Strains	__ High Blood Pressure __ Heart Attack __ Chest pain __ Poor Circulation __ Cold hands/feet __ Irregular heart beat __ Stroke __ Blood clots __ Swelling in feet/hands __ Varicose veins	__ Tightness in the chest __ Asthma __ Chronic Cough __ Coughing blood __ Spitting phlegm __ Difficulty Breathing __ Shortness of breath __ Wheezing

GASTRO-INTESTINAL	GENITO-URINARY	EYE/EAR/NOSE/THROAT	FOR WOMEN ONLY
__ Excessive hunger __ Excessive thirst __ Belching/Gas __ Frequent hiccups __ Nausea __ Vomiting __ Vomiting blood __ Burning pain after eating __ Bad breath __ Constipation __ Loose stools __ Diarrhea __ Black Stool __ Bloody Stool __ Mucus in stool __ Hemorrhoids __ Burning/itchy anus __ Poor digestion __ Poor appetite __ Weight Loss/Gain __ Abdominal pain/bloating __ Gallbladder stones	__ Painful urination __ Blood in urine __ Frequent urination __ Decreased urination __ Decreased strength of flow __ Unable to hold urine __ Urgency to urinate __ Frequent UTIs __ Frequent night urination __ Kidney stones __ Prostate problems __ Loss of Bladder Control __ Itching in the genitals __ Sores in genitals __ Impotency __ Increased libido __ Decreased libido __ Premature ejaculation	__ Pain behind eyes __ Dry, itchy or red eyes __ Excessive tearing __ Poor/blurry vision __ Night blindness __ Eye floaters __ Earache __ Ear Noises (ringing) __ Poor hearing __ Nasal Blockage __ Nose Bleeds __ Sinus problems __ Frequent Colds __ Swollen glands __ Thyroid problems __ Lump in throat __ Sore Throats __ Dry mouth/throat __ Excessive salvia __ Sores in mouth __ Teeth/gum pain __ TMJ disorder __ Grinding teeth	__ Birth Control _____ __ Hormone Replacement __ Hot flashes __ Cramps/Backaches __ Excessive Flow __ Light flow __ Irregular Cycle __ Painful Periods __ Blood clots __ Painful intercourse __ Vaginal discharge __ Vaginal dryness __ Breast Pain __ Breast lumps __ Pregnancies # _____ __ Miscarriages # _____ __ Abortions # _____ Pregnant at this Time Y/N Date of last period:

PSYCHOLOGICAL	SKIN OR ALLERGIES	FOR CHILDREN ONLY	OTHER
__ Anxiety __ Depression __ Bipolar __ Addictions __ Excessive fearfulness __ Difficulty making decisions __ Easy to anger __ Excessive worry __ Irritability __ Easily stressed __ Emotional/physical abuse __ Difficulty sleeping	__ Acne __ Bruising Easily __ Skin Dryness __ Dandruff __ Loss of hair __ Eczema/Dermatitis __ Rashes/Hives __ Itching __ Swelling under the skin __ Scars/keloids __ Sensitive Skin __ Spontaneous sweating __ Night sweating __ Allergy _____	__Birth trauma __Bedwetting __Childhood vaccine reactions __Congenital conditions __Developmental delays __Difficulty paying attention __Emotional outbursts __Food allergies/aversions __Frequent ear infections __Hyperactivity	Please use this space to comment on anything not mentioned within these boxes: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____

CHEMICAL HISTORY

1) Please list any prescription or over-the-counter medications you are currently taking (dosages and how long you have been taking):

1._____ 2._____
3._____ 4._____
5._____ 6._____

2) Were you previously taking any medication regularly? Which Ones / How long?

1._____ 2._____
3._____ 4._____

3) Please list any vitamins, supplements, herbs, or homeopathics you are currently taking (dosages and how long you have been taking them):

1._____ 2._____
3._____ 4._____
5._____ 6._____

4) Do you now, or in the past have a history of alcohol / drug abuse or heavy use? □Yes □No
Please describe:

_____
_____

4) Do you or did you work with any chemical, fume, dust, powder, smoke for prolonged periods?
□Yes □No Explain_____

5) Please indicate how much of the following products you consume:

Soda: _____ cups per day	Coffee:_____ cups per day	Alcohol: _____ drinks per week
Refined sugar: _____ x/day	Artificial sweetners: _____ x/day	White grains: _____x/day

EMOTIONAL HISTORY

With each of the following potential spinal stress situations, please indicate the severity either past or current

Potential Spinal Stress/Tension Sources	**PAST**	**CURRENT**
Childhood Stress	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
School Stress	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Family Stress	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Personal Relationships	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Stress of Being Sick	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Work Stress	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Loss of Loved One	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Change in Lifestyle	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Change in Vocation	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Abuse (Verbal, Physical, Emotional, Sexual, etc)	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme

OVERALL STRESS SURVEY

Please grade your Current Life Stresses using the following scale:
0 - *No* awareness of any stress 1 - *Slightly* stressful 2 - *Moderately* stressful 3 - *Extremely* stressful

0 1 2 3	***Overall Physical Stress/Trauma:*** (includes: falls, accidents, injuries, repeated postural stress, impacts, difficult birth, physical abuse, loss of consciousness, broken/fractured bones, etc.)
0 1 2 3	***Overall Emotional/Mental Stress:*** (includes: loss of loved ones, rapid change in life situations, abuse, move of /school, legal concerns, financial concerns, divorce, relationships, etc)
0 1 2 3	***Overall Chemical Stress:*** (includes: prescription drugs, smoke, alcohol, caffeine, fumes, food additives, anesthesia from surgery, over-the-counter medications, etc.)

YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE?

What is your commitment level to improve your health? _____%

What are your goals with us, and how will you measure the success of your care under them?
1._____
2._____
3._____

2) Is there anything else you may wish to share which may help us to better understand you, your history, or your professional and personal needs which have not been discussed in this profile?
_____
_____
_____

Signature: _____ Date: _____