

Practice Member Profile
(Adult)

Personal Information:

Name: _____ Birth Date: _____ Age: _____

Address: _____ Sex: Male / Female

City: _____ State: _____ Zip: _____ Home Phone: _____

Social Security: _____ Cell Phone: _____

Driver's License #: _____ E-mail Address: _____

Business Employer: _____ Fax #: _____

Occupation: _____ Business Phone: _____

Name of Spouse: _____ Spouse's Employer: _____

Type of Work: _____ Names & Ages of Children: _____

Referred To This Office By: _____

Name & Number of Emergency contact: _____ Relationship: _____

Who is Responsible for your bill, you and Spouse Auto Insurance Medicare Insurance

Personal Health Insurance Carrier: _____ Health Card ID #: _____

Insured Person's Name: _____ Group #: _____

Insured Person's Date of Birth: _____ Insured Person's Social Security #: _____

Health Information:

What are your objectives for consulting our office? _____

What are your health goals once these objective have been met? _____

Who was the last doctor who created a health development plan for you? _____

What were your results? _____

What other wellness professionals are currently part of your health care team? _____

Massage Therapist Acupuncturist Naturopath Homeopath Other _____

How many Medical Doctor's office visits did you and your family have last year?

None Less than 5 More than 5 More than 10

Date of last visit _____

Have you had previous chiropractic care? Yes No This year? Yes No

List previous surgeries and dates: _____

Please list all drugs you are taking (including prescription, non-prescription drugs, such as birth control, aspirin, heart medication, laxatives, cold tablets, or allergy medication)

Medication _____ Purpose _____

Medication _____ Purpose _____

Medication _____ Purpose _____

Medication _____ Purpose _____

Females Only:

Date of last cycle: _____ Is there any chance that you might be pregnant? Yes No

Number of pregnancies? _____ Miscarriages? _____

Health History:

Please indicate which of the conditions below you have experienced. Mark all that you have had in the past 6 months with a check.

- | | | |
|---|--|---|
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Dislocated Joints | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Aids | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Reproductive Trouble |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> German Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Bone Fracture | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bowel Control Loss | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Serious Injury |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Tire/Fatigued |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Disorder | <input type="checkbox"/> Tuberculosis |

- | | | |
|-------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> V.D. |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Multiple Dystrophy | <input type="checkbox"/> |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Neck Pain | |

Have either of your parents experienced any of the above conditions? _____

Lifestyle Information:

How would you describe your:

Diet: Poor Good Excellent

Rest: Poor Good Excellent

Exercise: Poor Good Excellent

Stress (Scale of 1-10, 10 being the most stressful) Occupational Stress _____ Personal Life _____

Do you take any Vitamins or Herbs? Yes No

Are you a member of a health club? Yes No

Do you buy bottled water? Yes No

I understand that Southwest Natural Health Center may notify me by phone.

I understand all treatments, x-rays and examinations are to be paid for as they are received or there has been a definite financial arrangement made in advance.

Assignment of Benefits: I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical benefits directly to Southwest Natural Health Center for any charges that I may incur.

Patients Signature: _____ Date: _____

Patient Name: _____

DOB: _____

Exam Date: _____

Please answer each of the following questions in sections 1 & 2

Section 1: Chief Complaints List in order of most severe first and be specific. When applicable indicate Left, Right, or Both Example → Low Back pain & Stiffness	When did you first notice this complaint?	What makes your symptoms worse?	How often do your symptoms bother you?	Did your symptoms appear suddenly, or slowly overtime?	Is your symptom increasing in Intensity or Frequency? (if Yes, check all that apply. Otherwise leave blank
	2 months	Bending, lifting	Daily	<input type="checkbox"/> Suddenly <input type="checkbox"/> Slowly Overtime	<input type="checkbox"/> Intensity <input type="checkbox"/> Frequency
				<input type="checkbox"/> Suddenly <input type="checkbox"/> Slowly Overtime	<input type="checkbox"/> Intensity <input type="checkbox"/> Frequency
				<input type="checkbox"/> Suddenly <input type="checkbox"/> Slowly Overtime	<input type="checkbox"/> Intensity <input type="checkbox"/> Frequency
				<input type="checkbox"/> Suddenly <input type="checkbox"/> Slowly Overtime	<input type="checkbox"/> Intensity <input type="checkbox"/> Frequency
				<input type="checkbox"/> Suddenly <input type="checkbox"/> Slowly Overtime	<input type="checkbox"/> Intensity <input type="checkbox"/> Frequency
				<input type="checkbox"/> Suddenly <input type="checkbox"/> Slowly Overtime	<input type="checkbox"/> Intensity <input type="checkbox"/> Frequency

Section 2:

What do the above listed complaints prevent you from doing? Please be specific.

Do these complaints prevent you from being productive or effective at home or work? ___ Yes ___ No

If yes explain _____

Are you irritable as a result of your complains? ___ Yes ___ No if yes explain _____

If you take medication for these complaints do you think it is effective in eliminating your condition?

No ___ Yes ___ if yes How? _____

Do these complaints make you feel older? No ___ Yes ___ if yes explain _____

If these complaints are left alone and they continue to get worse, how do you think that will affect you?

- Vertebral Subluxations can cause dysfunction -

1. Which pain or condition you have checked is the worst?

2. How long has it bothered you?

3. Vertebral Subluxations can cause irritation to different fibers within nerves. Is your pain sharp or dull? _____

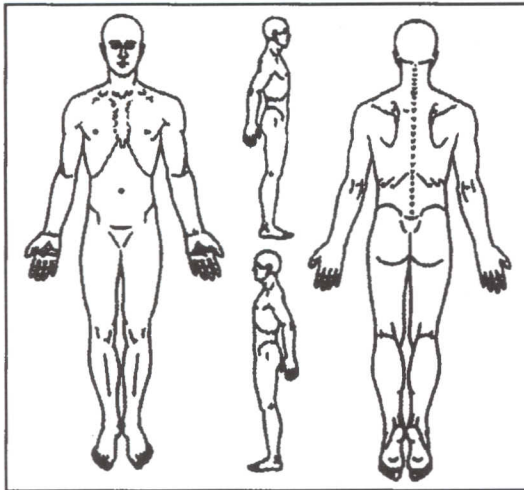
4. Subluxations can put pressure on the spinal cord which can be constant or occasional. Which do you feel? _____

5. Subluxation weakens your spine. Is your problem worse in the AM or PM?

6. Does this pain radiate into an extremity or stay in one area?

7. Subluxations can affect different fibers within nerves. On the diagram below, please show where you are experiencing all of your present complaints using the following letters:

A: ache B: burning C: cramping D: dull pain R: throbbing pain N: numbness T: tingling



8. Do you have pain and/or difficulty performing any of the following activities: (Check)

- personal care _____
- lifting _____
- reading _____
- concentrating _____
- work _____
- driving _____
- sleeping _____
- recreation _____
- walking _____
- sitting _____
- standing _____

9. Have you lost time from work because of it? Yes No
 Dates? _____ To _____

10. On the scale below, please circle the severity of your main complaint (at it's worst)

<i>None</i>	<i>Slight</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>					
1	2	3	4	5	6	7	8	9	10

NEW PATIENT CONSULTATION

Our patients have had literally dozens of impacts that could cause subluxations. We want to discover several of yours.

1. When was your most recent auto accident? _____
 - a. Speed: _____
 - b. Front or side collision / or rear-end?
 - c. Was chiropractic treatment received? YES / NO If yes, where?

 - d. Please list ALL other auto accidents (Include dates) _____

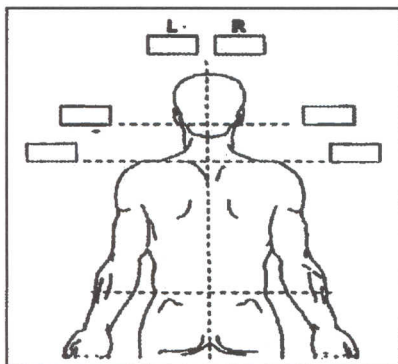
2. When was your most recent stress or strain at work? _____
 - a. Was any treatment needed? YES NO b.
 - When was the one before that? _____
 - c. What type of jobs have you done? _____

3. What sport or recreational activities do you do? _____
 - a. When was your most recent stress or strain during your activity? _____

 - b. Was any treatment received? YES NO
 - c. When was the one before that? _____

4. Is there any other injury to your spine, minor or major, that the Doctor should know about? _____

Office Use Only:



Bilateral Weight Scales

Left

Right