

Welcome to Picture of Health Family Chiropractic! Please take a few moments to answer the following questions so that I can get a well-rounded picture of your overall health, and therefore serve you to my greatest ability.

Name _____ Date of Visit _____
Address _____ City/State/Zip _____
Home Phone _____ Work/Cell Phone _____ Birth date _____
Occupation _____ Insurance? _____ Name of Company _____
Physician or Primary Health Care Provider(s) _____

Reason for today's visit: _____

Do you currently, or have you any history of cancer, stroke, cardiovascular disease, or diabetes? _____

Significant family history (cancer, cardiovascular disease, diabetes, stroke, etc.) _____

Please mark areas where your body has felt or is currently feeling a lack of ease or discomfort.

<input type="checkbox"/> head	<input type="checkbox"/> face	<input type="checkbox"/> neck	<input type="checkbox"/> chest	<input type="checkbox"/> shoulders	<input type="checkbox"/> arms
<input type="checkbox"/> sternum	<input type="checkbox"/> rib cage	<input type="checkbox"/> abdomen	<input type="checkbox"/> elbows	<input type="checkbox"/> wrists	<input type="checkbox"/> fingers
<input type="checkbox"/> upper back	<input type="checkbox"/> mid back	<input type="checkbox"/> low back	<input type="checkbox"/> buttocks	<input type="checkbox"/> tail bone	<input type="checkbox"/> legs
<input type="checkbox"/> feet	<input type="checkbox"/> toes	<input type="checkbox"/> knees	<input type="checkbox"/> breathing	<input type="checkbox"/> sacrum	<input type="checkbox"/> clavicle
<input type="checkbox"/> heart	<input type="checkbox"/> lungs	<input type="checkbox"/> ankles	<input type="checkbox"/> eyes	<input type="checkbox"/> hips	<input type="checkbox"/> hands

Please mark areas where you have experienced problems:

<input type="checkbox"/> thyroid	<input type="checkbox"/> nervousness	<input type="checkbox"/> sweating	<input type="checkbox"/> headaches	<input type="checkbox"/> allergies	<input type="checkbox"/> digestion
<input type="checkbox"/> circulation	<input type="checkbox"/> depression	<input type="checkbox"/> memory	<input type="checkbox"/> vision	<input type="checkbox"/> prostate	<input type="checkbox"/> circulation
<input type="checkbox"/> fatigue	<input type="checkbox"/> anxiety/panic	<input type="checkbox"/> speech	<input type="checkbox"/> eyes	<input type="checkbox"/> urinary	<input type="checkbox"/> appetite
<input type="checkbox"/> constipation	<input type="checkbox"/> blood pressure	<input type="checkbox"/> breathing	<input type="checkbox"/> sleep	<input type="checkbox"/> weight	<input type="checkbox"/> diarrhea
<input type="checkbox"/> blood clots	<input type="checkbox"/> tasting	<input type="checkbox"/> stress	<input type="checkbox"/> hearing	<input type="checkbox"/> asthma	<input type="checkbox"/> incontinence
<input type="checkbox"/> smelling	<input type="checkbox"/> spine	<input type="checkbox"/> gas	<input type="checkbox"/> tumors	<input type="checkbox"/> organs	<input type="checkbox"/> dizziness
<input type="checkbox"/> fainting	<input type="checkbox"/> varicose veins	<input type="checkbox"/> sciatica	<input type="checkbox"/> weakness	<input type="checkbox"/> sinuses	<input type="checkbox"/> other

IMMUNE SYSTEM

In general, how do you tend to heal? ___ slowly ___ average ___ quickly

How many colds/flu's do you experience each year? _____

When do you have a cold/flu, how many days do they last? _____

How do you take care of yourself when you don't feel well? _____

Are you currently experiencing, or have you in the past experienced any immune system disorders? (e.g. Epstein-Barre, Thyroid issues, Lupus, HIV, etc) _____

NERVOUS SYSTEM

Are you currently, or have you in the past had problems with any of the following?

<input type="checkbox"/> dizziness	<input type="checkbox"/> radiating pain	<input type="checkbox"/> panic attacks/	<input type="checkbox"/> walking
<input type="checkbox"/> tingling	<input type="checkbox"/> muscle spasms	<input type="checkbox"/> anxiety	<input type="checkbox"/> falling down
<input type="checkbox"/> tremors	<input type="checkbox"/> numbness	<input type="checkbox"/> muscle weakness	<input type="checkbox"/> other
<input type="checkbox"/> coordination	<input type="checkbox"/> balance	<input type="checkbox"/> nervousness	

REPRODUCTIVE SYSTEM

Women:

Are you pregnant? _____ If so, due date _____

Where do you plan to give birth? home birth center hospital other
How many children do you have? _____ # of pregnancies _____ Are you on birth control? _____
Do you experience any menstrual problems/irregularities? _____
Any breast changes/concerns? _____
Are you going through, or have you gone through menopause? _____ Any concerns? _____
Have you had a hysterectomy? _____ If so, when? _____ Hormone replacement therapy? _____
Do you have any other reproductive concerns? _____

Men:

Are you noticing any changes in your reproductive system that are causing you concern? _____
Any urinary problems/changes/difficulty? _____
When was your last physical exam? _____

ACCIDENTS/TRAUMA

List any accidents, falls, athletic injuries, and other physical traumas: _____

Have you ever been admitted into a hospital? _____ If so, why? _____

Do you know anything about your birth process? yes no

Please answer the following according to your comfort level:

Have you experienced any emotional trauma from which you have not yet recovered? yes no
Have you ever experienced any form of abuse? yes no

LIFESTYLE

What do you do to take time for yourself, that brings you joy and/or feeds your soul? _____

Do you participate in yoga, meditation, or any other spiritual practice? yes no If so, please describe _____

Do you participate in any exercise or sports? _____

How would you describe yourself in the following areas?

Emotional health _____

Physical health _____

Mental health _____

Overall quality of life _____

Mark all health care treatments you have utilized:

chiropractic homeopathy herbs
 massage acupuncture colonics
 other forms of bodywork acupressure other _____

When you are not feeling well, your first choice of health care is: holistic medical other

List all medications (prescription and over the counter) you are currently taking: _____

List all vitamins, herbs, and/or supplements you are currently taking: _____

Mark all of the following that you use regularly:

alcohol recreational drugs caffeine
 tobacco soft drinks aspartame (nutrisweet)