

Welcome to Dobrich Chiropractic & Wellness Center!

As a full spectrum chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future.

Name _____ Date _____
Age _____ Date of Birth _____ Sex _____
Address _____
City _____ State _____ Zip _____
Occupation: _____ Employer _____
Phone#: Home _____ Cell _____ Work _____
E-mail: _____

How did you hear about our office? _____

Are you: Single Married Partnered Widowed Divorced

Spouse/Partner Name: _____

How many Children do you have (include ages)?: _____

Emergency Contact: Name _____

Relationship _____ Phone # _____

Reason for consulting our office _____

Circle ALL goals that apply:

1. I would like symptom relief!
2. Help me prevent this from happening again!
3. Help me attain and maintain optimal health!
4. Other _____

Have you ever had chiropractic care? Y N Reason: _____

Have you ever had acupuncture? Y N Reason: _____

Did you have a positive experience? Y N Reason: _____

___ If you have NO symptoms and are here for Wellness Services, please check here, skip the section below and complete the back of the page.

What symptoms are you experiencing? _____

When did your symptoms appear? _____

What is the cause of your symptoms? _____

What relieves your symptoms? _____

What aggravates your symptoms? _____

Are your symptoms: constant or intermittent (come and go)

On a scale of 0-10 (10 being worst), grade your symptoms Now: _____ / At worst: _____

Please circle all that apply to your symptoms: (indicate location if multiple areas apply)

Achy Dull Sharp Tight Stabbing Numb Tingling Burning Shooting

Other: _____

Have you seen any other Doctors for this problem? ___ Yes ___ No

If Yes, who and what type of Doctors have you seen? _____

Your Health Profile

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Childhood Years – Age 0 To 17 (Please circle)

Did you have any childhood illnesses? Yes No Unsure
Were you vaccinated? Yes No Unsure
Were there any prolonged uses of medications/inhalers? Yes No Unsure
Did you experience any injuries resulting from sports or accidents? Yes No Unsure
Did you suffer any other traumas (physical or emotional)? Yes No Unsure
Were you under regular Chiropractic Care? Yes No Unsure

Adult Years – Age 17 to present (Please circle)

Have you been in any accidents? Yes No Explain _____
Do/did you smoke? Yes No If yes, how long? How many packs per day? _____
Do/did you drink alcohol? Yes No If yes, How many drinks per day? _____

On a scale of 0-10 describe your stress level. (0 – None ; 10 – Extreme)

Occupational Stress _____ Personal Stress _____

On a scale of Poor, Good, Excellent describe the following:

Diet _____ Exercise _____ Sleep _____ General Health _____

Please mark all the symptoms you have now with “**N**” and all symptoms you have had in the past with “**P**” even if they do not seem related to your current problem:

<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Pins and Needles in legs	<input type="checkbox"/> Fainting	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Loss of smell	<input type="checkbox"/> Pins and Needles in arms	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Loss of balance
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Buzzing in ears	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Nervousness
<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/> Numbness in toes	<input type="checkbox"/> Loss of taste	<input type="checkbox"/> Stomach upset
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Depression	<input type="checkbox"/> Irritability	<input type="checkbox"/> Tension
<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Neck Stiff	<input type="checkbox"/> Cold hands	<input type="checkbox"/> Cold feet
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Fever	<input type="checkbox"/> Hot flashes
<input type="checkbox"/> Cold sweats	<input type="checkbox"/> Lights bother eyes	<input type="checkbox"/> Problem urinating	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Mood swings	<input type="checkbox"/> Menstrual pain	<input type="checkbox"/> Menstrual Irregularity	<input type="checkbox"/> Ulcers

Please list **ALL** health problems you **currently** have: _____

Please list **ALL** health problems you have had in the **past**: _____

Please list **ALL** medications you are currently taking and **what you are taking each for**: _____

Please list **ALL** herbs and supplements you are currently taking and **what you are taking each for**: _____

Please list **ALL** surgeries that you have had. **Include the date and reason for each surgery**: _____

Are you pregnant or is there a chance you may be pregnant? _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Signature

Date