Return to Health CHIROPRACTIC

Name:_____ Date:_____

Address:_____ City:_____ Postal Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

E-Mail:_____ Age:_____ Birthdate: _____/_____/_____
Would you like to receive our newsletters? Yes □ No □ mm dd yy

Single _ Married _ Divorced _ Widowed _

Reason for consulting our office?_____ or wellness care?

List any medications_____

Who may we thank for referring you to our office?_____

Past Chiropractic Care? Yes___ No___ Dr:_____ Occupation:_____

List any supplements/vitamins you are taking:_____

How many glasses of water do you drink a day?:_____

Family Doctor's Name & Address:_____

Health Profile

Please check the choice that best describes your current goals for your health and well-being.

□ I am only concerned about relief of a particular symptom.
□ I am only concerned about relief of a particular symptom and preventing its return.
□ I want optimum health and well-being on every level available to me.
□ Rate your current health from 0 – 100_____. Where would you like that # to be?_____

	Yes	No	Unsure
Did you have any childhood illness?	□	□	□
Did you have any serious falls?	□	□	□
Are you using any medicine such as antibiotics or an inhaler?	□	□	□
As a child, were you under regular chiropractic care?	□	□	□

	Yes	No
Do/did you smoke?	□	□
Do/did you play in any adult sports?	□	□
Do/did you drink alcohol?	□	□
Have You been in any accidents?	□	□
Have you had any surgery?	□	□

Rate the following on a scale of 1 (none/good) to 10 (extreme/bad)

Stress (occupational)____ Stress (personal)____ Diet_____
Exercise_____ Sleep_____ General Health_____

Addressing the issues that brought you to the office.

If you are experiencing pain, it is… □Sharp □Dull □Comes and Goes □Travels □Constant
Since the problem started, it is… □About the same □Getting better □Getting Worse

What makes it worse?_____
It interferes with: □Work □Sleep □Walking □Sitting □Hobbies □Leisure

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

□ Headaches	□ Pins and needles in legs	□ Fainting	□ Dizziness
□ Neck pain	□ Pins and Needles in arms	□ Loss of smell	□ Back pain
□ Loss of balance	□ Buzzing in ears	□ Ringing in ears	□ Nervousness
□ Numbness in fingers	□ Numbness in toes	□ loss of taste	□ Depression
□ Stomach upset	□ Fatigue	□ Irritability	□ Tension
□ Sleeping problems	□ Neck stiff	□ Cold hands	□ Cold feet
□ Diarrhea	□ Constipation	□ Cold sweats	□ Fever
□ Lights bother eyes	□ Problems urinating	□ Menstrual pain	□ Heartburn
□ Menstrual irregularity	□ Hot flashes	□ Mood swings	□ Ulcers

Return To Health Chiropractic accepts payments by cash, cheque, Debit card and Credit Card. I understand that all services are to be paid in full at the time of service, unless alternate arrangements have been made and agreed upon in writing. _____(initial here please)
The statements 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

Doctor Notes:

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