Name: ______________________ Date: ______________________

Address: ______________________ City: ______________ State: ______ Zip: __________

SS#: ______________ DOB: ____________ Age: _____ ○ Male ○ Female Height: ______ Weight: ______

Home #: ______________ Work #: ______________ Cell #: ______________

Best time to contact: ____________ How did you hear about us? ______________________

Email address: ______________________ Status: ○ Single ○ Married ○ Divorced ○ Widowed

Number of Children: ________ Names/Ages: ______________________________

Occupation: ____________ Employer Name/Phone: ______________________________

Your Health Profile

What brings you into our office today? Please briefly describe any health symptoms, including the impact it has had on your life. Please rate the severity (scale 1-10, 1 being mild). Also include when and how did this start? Are symptoms constant or intermittent?

____

____

____

____

Since the problem started it is: ○ the same ○ getting better ○ getting worse

What makes the problem worse? ______________________________________

____

What, if anything makes the problem better? ______________________________

____

Does this interfere with your: ○ Leisure ○ Work ○ Sleep ○ Sports ○ Other____________

____

Have you seen other doctors for this condition? ○ Chiropractor ○ MD

Other Name/Address: ______________________________ Date: ____________

What was the diagnosis: ______________________________________

General Health

Please list all medications and supplements you are taking, and why. (Prescription and non-prescription) ____________

____

____

____

Have you had any surgeries and/or hospitalizations? ○ Yes ○ No

If yes, briefly explain: ______________________________

____

____

Have you ever had any work related injuries? ○ Yes ○ No

If yes, briefly explain: ______________________________

____

Have you ever had any slips, falls or auto accidents? ○ Yes ○ No

If yes, briefly explain: ______________________________

____

Do you have a history of sexual abuse? ○ Yes ○ No

If yes, have you sought professional counseling? ○ Yes ○ No

Please check all symptoms you have currently (C) or have had in the past (P), even if they do not seem related to your current problem. You may write notes to explain, if desired.

(C)	(P)		(C)	(P)	
○	○	Headaches	○	○	Fever
○	○	Pins & needles in arms	○	○	Dizziness
○	○	Pins & needles in legs	○	○	Numbness in fingers
○	○	Sleeping problems	○	○	Fatigue
○	○	Tension	○	○	Urinary problem
○	○	Acid reflux or ulcers	○	○	Fainting
○	○	Buzzing in ears	○	○	Eyes bothered by light
○	○	Ringing in ears	○	○	Stomach problems
○	○	Numbness in toes	○	○	Diarrhea
○	○	Depression	○	○	Cold sweats
○	○	Constipation	○	○	Mood Swings
○	○	Menstrual pain	○	○	Loss of smell
○	○	Menstrual irregularity	○	○	Loss of taste
○	○	Hot flashes	○	○	Back pain
○	○	Irritability	○	○	Neck Pain
○	○	Cold hands	○	○	Stiff neck
○	○	Cold feet	○	○	Digestive problems:

Current Lifestyle

On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/psychological/lifestyle stress levels:

Scale =____ Occupational stress: ______________________________

Scale =____ Personal stress: ______________________________

Please indicate what you consume in a typical day:

Breakfast: ______________________________

Snack: ______________________________

Lunch: ______________________________

Snack: ______________________________

Dinner: ______________________________

Beverages: ______________________________

Habits (please check all that apply):

- ○ Alcohol
- ○ Laxatives
- ○ Chocolate
- ○ Tea
- ○ Sugar
- ○ Sugar Substitute
- ○ Cigarettes
- ○ Coffee

Do you consider yourself: ○ Overweight ○ Average ○ Underweight

Describe activity level: ○ Sedentary ○ Light ○ Moderate ○ Heavy

How many meals do you typically eat out in a week? _____ How many glasses of water do you drink daily? _____

List any foods you crave: ______________________________

List any foods you avoid (for any reason): ______________________________

At our office we're concerned about your health and wellness goals. Please take a moment to list your goals in the following categories:

Be Fit. (Physical)	Eat Right. (Nutritional)	Think Well. (Psychological)

Provider

Please indicate if would like to see a specific doctor. If you have no preference you may leave this blank.

○ Dr. Sarah Weber ○ Dr. Andrea Shavitz

I consent to a professional and complete chiropractic examination, and to any radiographic examination that the doctor deems necessary. I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date.

Signature: ______________________ Date: ______________

If you filled this form out at home, you may print it and bring it with you to your first appointment or email it to us at office@totalbalancechiro.com. Otherwise please return this form to the front desk and someone will be right with you.