Vitalize Chiropractic:
A Creating Wellness Center

4980 Benchmark Centre Dr., Ste. 100
Swansea, IL 62226

Tel (618) 624-9080
Fax (618) 624-9090

PERSONAL INFORMATION:

Name: _____Age:_____ Date: _____

Address: _____City/State/ Zip: _____

Home Phone #: (__)____-_____ Work Phone #: (__)____-_____ Cell Phone #: (__)____-_____

Email Address: _____ Male _____ Female: _____ DOB:_____

Occupation: _____Employer Name And Address:_____

Best Time To Contact: _____Status: Single Married Divorced Widowed

# of Children, Names and Ages: _____

_____

YOUR HEALTH:

*Please place an "X" on the scale above marking where you believe your level of health and wellness is at this time. Place a circle (o) on the diagram indicating where you would **like** your health and wellness to be.*

YOUR HEALTH PROFILE:

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History" page.

Health Concerns:	Rate Severity 1 = mild 10= worst imaginable	When did this start?	Are symptoms Constant or intermittent?	Did problem begin with injury?

_____

_____

_____

Since the problem started, it is…____The Same _____Getting Better _____Getting Worse
What makes the problem worse? _____
_____

What, if anything makes it feel better? _____
_____

Does this interfere with your: ____Work ____Leisure ____Sleep ____Sports ____Other:
_____

Have you seen other doctors for this condition? ___Chiropractor ___ Medical Dr.___Other
Name/ Address: _____
Date: _____What was diagnosis? _____

Name/ Address: _____
Date: _____What was diagnosis? _____

General History:

List all medications you are taking and why: (Prescription and non-prescription) _____
_____

Have you had any surgeries or hospitalizations? (Please include all surgeries)
_____
_____
_____

What do you do for a living? _____

Have you ever had any work related injuries? _____

Have you ever had any slips, falls or auto accidents?_____
_____

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	☐ Neck pain
☐ Pins and needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness
☐ Numbness in fingers	☐ Numbness in toes	☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Stiff Neck	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes	☐ Urinary Problem	☐ Heartburn
☐ Mood Swings	☐ Menstrual Pain	☐ Menstrual Irregularity	☐ Ulcers

On a scale of 1-10 describe your psychological/emotional stress levels:
(1= none/ 10=extreme)
Occupational: _____

Personal: _____

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating habits: _____Exercise habits:_____ Sleep: _____ General Health: _____ Mind-set:_____

YOUR GOALS: At our office we concern ourselves with YOUR health and YOUR wellness goals. Please list your goals for your health and wellness in the spaces provided.

Physical Goals:	Nutritional/ Biochemical Goals	Psychological Goals
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever:

Bought bottled water:	☐ Yes ☐ No
Belonged to a health club:	☐ Yes ☐ No
Consumed vitamins or supplements	☐ Yes ☐ No
If there is a need for dietary changes would you like to know?	☐ Yes ☐ No
If there is a need for specific exercises would you like to know?	☐ Yes ☐ No
If there is a need for support in the psychological/mind/body/stress dimension of health would you like assistance?	☐ Yes ☐ No

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

Signature_____ Date: _____

Thank you for filling out this form. It is your first step to Creating Wellness!
Return this to our staff and someone will be right with you.