

TRUE HEALTH FAMILY CHIROPRACTIC – Dr. Brycen A. Hudock

Date: _____ **Phone: H ()** _____ **W ()** _____ **Cell ()** _____
Name: _____
Address: _____ **City:** _____ **State:** _____
Zip: _____ **Age:** _____ **DOB:** _____ **S M W** **# of children:** _____
Occupation: _____ **E-mail address** _____
Who May We Thank For Referring You? _____

Your Health Profile

WHY THIS FORM IS IMPORTANT

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. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

THE BEGINNING YEARS (To Age 17)

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.

Your Childhood Years

	Yes	No	Unsure		Yes	No	Unsure
Did you have any childhood illnesses?				Was there any prolonged use of medicine such as antibiotics or an inhaler?			
Did you have any serious falls as a child?				Did you suffer any other traumas (physical or emotional)?			
Did you play youth sports?				Were you vaccinated?			
Did you take/use drugs?				As a child were you under regular Chiropractic care?			
Did you have any surgery?							
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, trees)							

Adult (18-Present)

	Yes	No		Yes	No
Do / did you smoke?			Do you play any adult sports?		
Do / did you drink alcohol?			Do / did you participate in extreme sports?		
Have you been in any accidents?			On a scale of 1-10 describe your stress level: (1=None / 10=Extreme)		
Comments: _____			Occupational: _____		
			Personal: _____		
On a scale using: Poor Good Excellent describe your:					
Diet _____	Exercise _____	Sleep _____	Mental Attitude _____	General Health _____	
List any previous surgeries: _____					
List current medications (prescription and non-prescription): _____					

Addressing The Issues That Brought You To The Office

If you have ***no symptoms or complaints*** and are here for **wellness services**, please check (✓) here: _____ **“I Wish to have Chiropractic Wellness Services”** and skip to **“Family Health Profile”**. Otherwise, **Briefly Describe The Chief Area Of Complaint, Including The Effect It Has Had On Your Life:**

If you are experiencing pain, is it....

- Sharp Dull Comes and goes Travels Constant

Since the problem started, it is.... About the same Getting better Getting worse

What makes it worse? _____

Yes, it interferes with: Work Sleep Walking Sitting Hobbies Leisure

Other Doctors seen for this problem: (please list)

Chiropractor _____

Medical Doctor _____

Other _____

How do you want us to handle this problem? Temporary Relief Maximum Correction

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 | Neck stiff | Cold hands | Cold feet |
| Diarrhea | Constipation | Fever | Hot flashes |
| Cold sweats | Lights bother eyes | Problem urinating | Heartburn |
| Mood swings | Menstrual pain | Menstrual irregularity | Ulcers |

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about you:

Children _____

Spouse _____

Mother/Father _____

Brothers/ Sisters _____

Others _____

Have you ever:

	Yes	No
Bought bottled water?	<input type="checkbox"/>	<input type="checkbox"/>
Belonged to a health club?	<input type="checkbox"/>	<input type="checkbox"/>
Consumed vitamins or supplements?	<input type="checkbox"/>	<input type="checkbox"/>

W 1 _____ 5 _____ 10

R

P S _____ L _____

E

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