

Well Life Center/Dr. Jeff Donahue, DC, L. Ac.

New Client Health Profile Form

Please tell us about yourself:

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Cell phone: _____

E-mail address: _____

Out of state address, if applicable: _____

City: _____ State: _____ Zip: _____

Social Security #: (optional) _____ Birth Date: _____

Sex (M/F): _____ Marital (S, M, D, W, Sep.): _____ Number of children at home _____

Occupation: _____ Employer: _____

In Case of Emergency, Contact: _____

Address: _____

Telephone: _____

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

As a wellness center, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to our office, and second, to offer you the opportunity of improved health, wellness and quality of life in the future.

Please fill out this next section if you have a current concern(s). If your current condition is the result of a recent auto accident, please inform the front desk staff immediately to obtain additional necessary paperwork.

If you have NO concerns, and are here for wellness care, please skip to section 2.

Primary concern: (list one only):

When did you first experience this problem? _____

How did this problem first begin? _____

How often do you experience this problem? () 1-2x/month () 3-4x/month () 2-5x/week () daily () constantly

Please grade the intensity of this problem (with 10 being the worst):

At its best 1 2 3 4 5 6 7 8 9 10

At its worst 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)?

Please describe the location of the concern: _____

Does this problem cause pain to travel to any other area? Y N If yes, where?

Is this problem getting: () worse () better () staying the same?

What seems to aggravate this problem? (movements, postures or positions, time of day, allergies, chemical exposures, emotional stresses, etc): _____

What seems to help relieve this problem, if anything (stretches, exercises, medication, lifestyle changes, etc)? _____

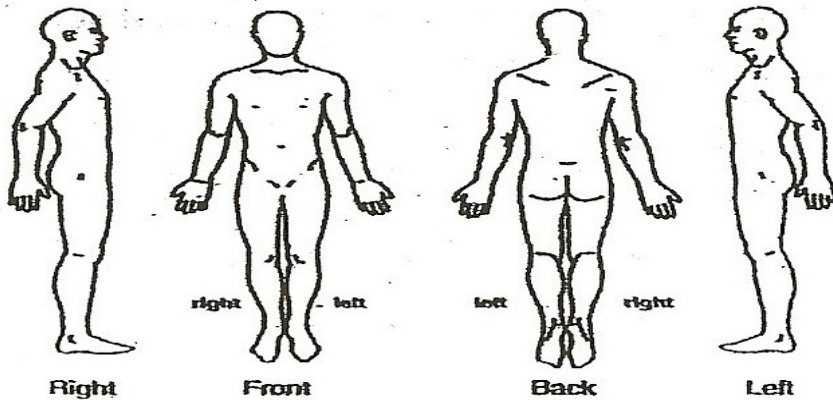
Have you seen any other doctors or other professionals for this problem? Y N If yes, who?

What treatment was given? _____

How effective was the care? _____

If you are experiencing pain, please indicate the location on the diagram below, using the symbols:

- Stabbing**
- +++++++
- Aching**
- /////
- Burning**
- =====
- Numbness**
- 00000000
- Pins & Needles**
- ^ ^ ^ ^ ^ ^ ^ ^



Second concern, if any (List only one):

When did you first experience this problem? _____

How did this problem first begin? _____

How often do you experience this problem? () 1-2x/month () 3-4x/month () 2-5x/week () daily () constantly

Please grade the intensity of this problem (with 10 being the worst):

At its best 1 2 3 4 5 6 7 8 9 10

At its worst 1 2 3 4 5 6 7 8 9 10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)?

Please describe the location of the concern: _____

Does this problem cause pain to travel to any other area? Y N If yes, where?

Is this problem getting: () worse () better () staying the same?

What seems to aggravate this problem? (movements, postures or positions, time of day, allergies, chemical exposures, emotional stresses, etc): _____

What seems to help relieve this problem, if anything? (stretches, exercises, medication, lifestyle changes, etc): _____

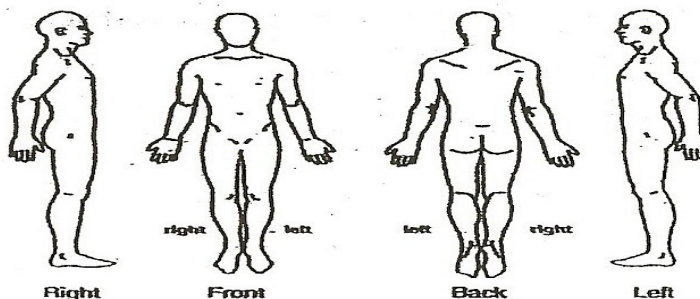
Have you seen any other doctors or other professionals for this problem? Y N If yes, who?

What treatment was given? _____

How effective was the care? _____

If you are experiencing pain, please indicate the location on the diagram below, using the symbols:

- Stabbing
+++++++
- Aching
/////
- Burning
=====
- Numbness
oooooooo
- Pins & Needles
^ ^ ^ ^ ^ ^ ^ ^ ^ ^



Medical History- Section 2:

Please check any of the following illnesses you have had:

- | | | |
|--|---|--|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Eczema |

Surgeries:

Date	Type	Reasons for surgery
------	------	---------------------

Previous injuries or trauma:

Type	Date
------	------

Medications (including over the counter drugs):

Medication	Reason for taking
------------	-------------------

Allergies (including food):

Family Information:

Please list the cause of death and age of any immediate family members (parents, siblings, children):

Relationship	Cause of Death	Age at Death
--------------	----------------	--------------

Women only:

Number of pregnancies _____ Number of children _____

Age and sex of each child (i.e. 10-F, 15-M): _____

When was your last period? _____

Is your menstruation regular? _____

Are you pregnant now? Y N Not sure

Please check any of the following you have had in the last six months:

Musculo-skeletal

- Low back pain
- Pain between shoulders
- Neck pain
- Arm pain
- Joint pain/stiffness
- Walking problems
- Hard chewing/clicking jaw
- General stiffness
- Headaches

Nervous system

- Nervous
- Numbness
- Paralysis
- Forgetfulness
- Confusion
- Depression
- Fainting
- Convulsions
- Cold/tingling extremities
- Stress
- Tremors
- Muscle weakness
- Loss of balance
- Memory loss
- Irritability

General

- Anemia
- Cancer
- Diabetes
- Epilepsy
- Excessive thirst

- Fatigue
- Fever
- Insomnia

Gastro-Intestinal

- Poor/excessive appetite
- Excessive thirst
- Frequent nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver problems
- Gall bladder problems
- Weight gain/loss
- Abdominal cramps
- Gas/bloating after meals
- Heartburn
- Black/bloody stools
- Colitis
- Ulcers

Cardio-vascular/Respiratory

- Chest pain
- Blood clots
- Shortness of breath
- Blood pressure problems
- Irregular heartbeat
- Heart problems
- Lung problems/congestion
- Varicose veins
- Ankle swelling
- Stroke
- Cold hands/feet

- Excessive phlegm
- Sinus problems
- Chronic coughing

Eyes, Ears, Nose and Throat

- Enlarged glands
- Vision problems
- Dental problems
- Sore throat
- Ear aches
- Loss of hearing
- Tinnitus
- Sinus problems
- Nose bleeds

Male/Female

- Menstrual irregularity
- Menstrual cramps
- Vaginal pain/infection
- Breast pain/lumps
- Prostate/sexual dysfunction
- Frequent urination
- Can't control urination
- Other problems:

Immune system

- Fibromyalgia
- Arthritis
- Gout
- Frequent colds/flu
- Allergies
- Rashes

Please continue to fill out the rest of this form if you are interested in how we may improve your overall health and wellness, above and beyond your listed concerns. If you are only interested in help for those concerns, you may finish by signing below.

I have filled out to the best of my knowledge everything in the above questions. There is nothing that has been left out about my past and present health conditions. I consent to a professional and as complete a chiropractic examination that the doctor deems necessary. I have read and agree to abide by the policies of this office.

Signed: _____ Date: _____

General Health, Lifestyle and Stress Information- Section 3:

General:

Please rate your overall health status:

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are your health objectives? _____

Name/address/phone of the last doctor who put you on a health development program: _____

Were you able to stay on the program? Y N How long? _____

What were your results? _____

Are you healthier today than you were 5 years ago? Y N Not sure

If so, what did you do to improve your health, or if not, why do you think your health declined? _____

Will you be healthier 5 years from now than you are today? Y N Not sure

If so, what are you doing to improve your health and if not, what could you do to improve your health rather than have it continue to decline? _____

Have you had previous chiropractic care? Y N

If yes, what was the doctor's name? _____

What was the approximate date of your last visit? _____

How long did your care last at that time? _____

What other wellness professionals are currently part of your health care team?

() Massage therapist () Acupuncturist () Naturopath () Homeopath () Other: _____

How many Medical Doctor's office visits did you and your family have last year? () None () Less than 5

() More than 5 () More than 10

Lifestyle:

On a scale of 1-10 (where 0 is none, and 10 is the most imaginable), please rate your stress level:

Occupational _____

Personal _____

Do you smoke or chew tobacco? Y N If yes, how much? _____

Do you drink alcohol? Y N If yes, how much? _____

Do you drink coffee/tea? Y N If yes, how much? _____

Do you drink soda? Y N If yes, how much? _____

Do you drink water? Y N If yes, how much? _____

Do you use recreational drugs? Y N If yes, how much? _____

Recreational activities:

How regularly do you exercise? daily ____x/week occasionally never

What kinds of exercise do you do? aerobic weight lifting yoga stretching calisthenics

Have you ever been given advice from your physician not to exercise? Y N _____

Do you have any negative feelings toward exercise? Y N _____

Do you have any problems with sleeping? Y N _____

How many hours of sleep do you get, on average, per night? _____

How many times per day do you eat? _____

How would you rate your diet/food choices? (0 is poor, i.e. fast foods/ 10 is excellent, i.e. organic)

poor 1 2 3 4 5 6 7 8 9 10 excellent

Do you crave any foods, and if yes, which ones? _____

Are you on any diet or eating plan? _____

Do you feel you need to gain or lose weight? _____

Do you have any food allergies? Y N _____

Number of bowel movements per day: _____

List the nutritional supplements that you use regularly:

If you don't use supplements regularly, do you have any negative feelings toward them? Y N

Stress History:

Please check or circle whether you have ever experienced increased stress in any of the following areas.

Childhood

Structural stress

- Falls
- Jumps over 3 feet in height
- Head trauma
- Birth trauma
- Youth sport injuries

Chemical Stress

- Repeated/prolonged antibiotic use
- Inhaler use
- Prescription medication
- Vaccinations

Emotional Stress

- Parental divorce/separation
- Abandonment
- Feeling of not fitting in
- Depression
- Anxiety
- Fear

Adulthood

Structural stress

- Car Accidents
- Fall/Jumps
- Head Trauma
- Sports injuries
- Contact injuries
- Extreme Sports

Chemical stress

- Alcohol consumption
- Prolonged antibiotic use
- Coffee drinking (> 1 cup)
- Illegal drug use/abuse
- Prescription drug use/abuse
- Inhaler use
- Smoker
- Exposure to chemicals

Emotional stress

- Depression
- Anxiety
- Fear
- Family stress
- Work stress
- Money worries