2055 Third Ave., Suite B, San Diego, CA 92101 ● (619) 239-0053 ● www.warrenfamilywellness.com

YOUR WELLNESS HISTORY – Health Profile

NAME: ____ DATE: __________________

ADDRESS: ____

CITY / STATE / ZIP: ____

HOME PHONE #: _______________ WORK PHONE #: ______________ CELL #: ______________

E-MAIL ADDRESS: ____ __________________

BIRTH DATE: ______________ AGE: _____ ☐ Male ☐Female MARITAL STATUS: ☐ Single ☐ Married

OCCUPATION: ____________________________ EMPLOYER'S NAME: ______________________

OF CHILDREN: _______ NAMES & AGES: ____

____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ________________________________

Rate your Health and Wellness

Place an 'X' that denotes where you believe your current level of wellness to be.
Place an 'O' indicating where you would like your wellness to be.

YOUR HEALTH PROFILE

► What brings you into our office today?

Please briefly describe, including the impact it has had on your life. If you are here for chiropractic wellness services only, please skip this part and go to "General History" on the next page.

Rate Severity (scale 1-10) When & How did this start? Have you experienced this before? Are symptoms constant or intermittent?

____

____

► Since the problem started, is it: ☐ the same ☐ getting better ☐ getting worse?

What makes the problem worse? ____

What, if anything, makes the problem feel better?___________________________________

► Does this interfere with your: ☐ Leisure ☐ Work ☐ Sleep ☐ Sports/Recreation ☐ Other?

____

► Have you seen other doctors/practitioners for this condition? ☐ Chiropractor ☐ MD ☐ Other?

Name(s):____Date(s):________________

What was the diagnosis?____

GENERAL HISTORY

► List any medications 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: ____

____

► On a scale of 1-10 (1 = none, 10 = extreme), describe your current levels of lifestyle stress:

Scale = ____ Occupational stress: ____

Scale = ____ Personal stress: ____

► On a scale of 1-10 (1 = none, 10 = extreme), describe your habits and condition as it relates to:

____ Eating ____ Exercise ____ Sleep ____ Relaxation/Enjoyment ____ Overall Health ____ Wellness Lifestyle

Please check (☐) all symptoms you are currently experiencing, or have had significant difficulty with in the past:

☐ Headaches	☐ Asthma	☐ Tired after eating	☐ Lower back pain / stiffness
☐ Neck pain / stiffness	☐ Breathing problems	☐ Indigestion	☐ Sciatica
☐ Spacey / Brain Fog	☐ Fatigue / Low Energy	☐ Heartburn / Ulcers	☐ Pins & needles in legs
☐ Memory Trouble	☐ Sleeping problems	☐ Gas / Bloating	☐ Cold Hands / Feet
☐ Pins and needles in arms	☐ Overwhelmed by stress	☐ Diarrhea	☐ Diabetes
☐ Numbness in fingers	☐ Depression	☐ Constipation	☐ Osteoporosis
☐ Buzzing / Ringing in ears	☐ Irritability	☐ Urinary Problem	☐ Cancer
☐ Sinus Problems / Snoring	☐ Anxiety	☐ Menstrual Pain	☐ Heart Disease
☐ Allergies	☐ Dysmenorrhea (PMS)	☐ Menstrual Irregularity	☐ Autoimmune Disorder
☐ Frequent Colds / Flu's	☐ Hot Flashes	☐ Infertility	☐ Prolonged use of medication

☐ Any other symptoms not listed: ____

____

____

YOUR GOALS

► If you could have it *any* way you wanted it, what would your health and wellness be like? ________________________
____

► What is one thing you could **start** doing that would allow you to have it this way? ______________________________
____

► What is one thing you should **stop** doing that would allow you to have it this way? _____________________________
____

► What are your Health and Wellness Goals for yourself?
____
____

► With regard to what brought you into our office, are you interested in: ☐ temporary relief or ☐ permanent solutions?

If Lifestyle recommendations are appropriate for you, would you be interested in learning more about:

☐ Proper Nutrition and meal planning? ☐ Proper Exercise routines & techniques? ☐ How to deal with Lifestyle stress?

► Are there any other health concerns or anything else you'd like us to know about you? ☐ Yes ☐ No

If yes, please tell us: ____
____

Thank you for filling out this form.
It is your first step to **Creating Wellness!**

I consent to a professional and complete chiropractic examination and to any further examination procedures 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: ___________________

____

For Office Use Only:

Objectives: ☐ Relief/Correction ☐ Maintenance
☐ Stabilization-Strengthening/Prevention ☐ Wellness