Biddeford Family Chiropractic Patient Health Profile

NAME ______________________________ **DATE** ____________

ADDRESS ______________________ **CITY/STATE** ____________ **ZIP** ________

HOME PHONE ______________________ **MOBILE PHONE** ______________________

WORK PHONE/S ______________________ **BIRTHDATE** ______________________

OCCUPATION ______________________ **EMPLOYER** ______________________

SEX ___FEMALE ___MALE **MARITAL STATUS** ___SINGLE ___MARRIED ___DIVORCED ___WIDOWED

SPOUSE ______________________ **CHILDREN (NAMES/AGES)** ______________________

____

E-MAIL ADDRESS ______________________________

WHO REFERRED YOU TO US? ______________________________

PAST CHIROPRACTIC CARE? YES/NO DR.'S NAME/LOCATION ______________________

______________________________ **LAST VISIT** ____________

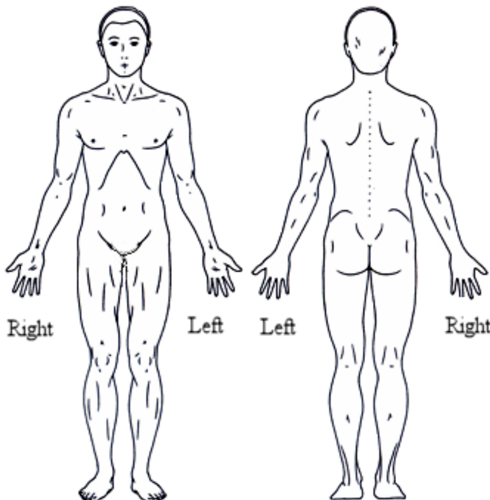
CURRENT MEDICAL CARE? YES/NO WHY? ______________________________

CURRENT DRUGS/MEDICATION ______________________________

Please list your health concerns below:

List health concerns according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	Are the symptoms constant or off and on?
1.____________	____________	____________	____________
2.____________	____________	____________	____________
3.____________	____________	____________	____________
4.____________	____________	____________	____________

Using the symbols below, please mark on the pictures where your health concerns are.



Numbness	= = =
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	/ / /
Pins, Needles	+ + +
Other ______	^ ^ ^

What makes it worse?______________________

What makes it better?______________________

Other doctors seen for this condition:

____Chiropractor ____Medical Doctor ____Other

When and Who?______________________________

Please CHECK how your health concerns are affecting your life:

☐ Restricted on daily activities ☐ Interrupts sleep ☐ Irritable ☐ Moody ☐ Unable to exercise

☐ Unable to work long hours ☐ Interferes with hobbies ☐ Restricts household duties

☐ Less patience with family ☐ Less energy ☐ Decreased productivity

Other:____

Please mark "P" for personal health history, "F" for family health history or "B" for both:

__Asthma	__Arthritis	__TMJ	__Chronic Fatigue	__Epilepsy
__Gastric reflux	__Lupus	__Ulcers	__Sciatica	__Irritable bowel
__Heart disease	__Nausea	__Dizziness	__Numbness/arms	__Numbness/legs
__Headaches	__Neck pain	__Migraines	__Numbness/hands	__Numbness/feet
__Stomach aches	__Vertigo	__Hip pain	__Sinus problems	__Menstrual pain
__Anxiety	__Shoulder pain	__Chest pain	__High BP	__Low BP
__Ear infections	__Low back pain	__Leg Pain	__Mid back pain	__Fibromyalgia
__Scoliosis	__Cancer	__Diabetes	__Stroke	__Spinal surgery

Other:____

____

Social History:

Alcohol Drinker?	___Yes ___No	If yes, ___Drinks per week
Cigarette Smoker?	___Yes ___No	If yes, ___Packs per week
Caffeine User?	___Yes ___No	If yes, ___Cups per day
Do you exercise?	___Yes ___No	If yes, ___Days per week

PLEASE CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR CURRENT GOALS FOR HEALTH/WELLBEING.

- ❑ I am only concerned about relief of a particular symptom.
- ❑ I am only concerned about relief of a particular symptom, and preventing its return.
- ❑ I want optimum health and wellbeing on every level available to me.

WE ACCEPT PAYMENT BY CASH, CHECK AND CREDIT CARD

I understand that all services are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing. Insurance information provided by Biddeford Family Chiropractic LLC is not a guarantee of benefit or payment. All services are subject to limitations and exclusions that are in effect at the time services are rendered.

Signature ______________________________________ Date ____________________