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
Did you have any childhood illnesses?			
Did you have any serious falls as a child?			
Did you play youth sports?			
Did you take/use drugs?			
Did you have any surgery?			
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, trees)			
Was there any prolonged use of medicine such as antibiotics or an inhaler?			
Did you suffer any other traumas (physical or emotional)?			
Were you vaccinated?			
As a child were you under regular Chiropractic care?			

Adult (18-Present)

	Yes	No
Do / did you smoke?		
Do / did you drink alcohol?		
Have you been in any accidents?		
Do you play any adult sports?		
Do / did you participate in extreme sports?		

On a scale of 1-10 describe your stress level: (1=None / 10=Extreme)
Occupational: _____
Personal: _____

Comments:_____

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 your:

Children _____

Spouse _____

Mother/Father _____

Brothers/ Sisters _____

Others _____

Have you ever:	Yes	No
Bought bottled water?	☐	☐
Belonged to a health club?	☐	☐
Consumed vitamins or supplements?	☐	☐

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1 _____ 5 _____ 10

S_____ L_____

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