

## Your Wellness History - Health Profile

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Best Time to Contact: \_\_\_\_\_

Email Address: \_\_\_\_\_ Status: Single Married Divorced Widowed

# of Children: \_\_\_\_\_ Names/ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer Name/ Address: \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

### Rate your health and wellness.

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



### Your Health Profile

• **Please list your health concerns:**

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

Rate Severity (Scale 1 -10, 1 being mild)      When and how did this start?      Are symptoms constant or intermittent?

\_\_\_\_\_

\_\_\_\_\_

• Since the problem started it is: \_\_\_\_\_ the same    \_\_\_\_\_ getting better    \_\_\_\_\_ getting worse

What makes the problem worse? \_\_\_\_\_

\_\_\_\_\_

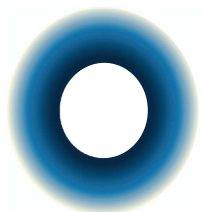
• What, if anything makes the problem feel better? \_\_\_\_\_

• Does this interfere with your: \_\_\_\_\_ Leisure    \_\_\_\_\_ Work    \_\_\_\_\_ Sleep    \_\_\_\_\_ Sports    \_\_\_\_\_ Other

• Have you seen other doctors for this condition? \_\_\_\_\_ Chiropractor    \_\_\_\_\_ MD    \_\_\_\_\_ Other

Name/ Address: \_\_\_\_\_

What was the diagnosis: \_\_\_\_\_



Thrive:  
A Creating Wellness  
Center

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Durango, CO 81301  
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Fax: (970) 259-3679

## Your Wellness History - Health Profile, page 2

### General History

- Please list all medications you are taking, and why. (Prescription and non-prescription.)

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- Have you had any surgeries and/or hospitalizations? \_\_\_\_ Yes \_\_\_\_ No

If yes, briefly explain \_\_\_\_\_

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- Have you ever had any work related injuries? \_\_\_\_ Yes \_\_\_\_ No

If yes, briefly explain \_\_\_\_\_

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- Have you ever had any slips, falls or auto accidents? \_\_\_\_ Yes \_\_\_\_ No

If yes, briefly explain \_\_\_\_\_

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Please check all symptoms you have ever had, even if they do not seem related to your current problem

Past	Present	Past	Present	Past	Present
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> Menstrual pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of smell
<input type="checkbox"/>	<input type="checkbox"/> Pins & needles in arms	<input type="checkbox"/>	<input type="checkbox"/> Menstrual irregularity	<input type="checkbox"/>	<input type="checkbox"/> Loss of taste
<input type="checkbox"/>	<input type="checkbox"/> Pins & needles in legs	<input type="checkbox"/>	<input type="checkbox"/> Hot flashes	<input type="checkbox"/>	<input type="checkbox"/> Back pain
<input type="checkbox"/>	<input type="checkbox"/> Numbness in toes	<input type="checkbox"/>	<input type="checkbox"/> Irritability	<input type="checkbox"/>	<input type="checkbox"/> Neck pain
<input type="checkbox"/>	<input type="checkbox"/> Numbness in fingers	<input type="checkbox"/>	<input type="checkbox"/> Cold hands	<input type="checkbox"/>	<input type="checkbox"/> Stiff neck
<input type="checkbox"/>	<input type="checkbox"/> Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Cold feet	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Sleeping problems	<input type="checkbox"/>	<input type="checkbox"/> Fever	<input type="checkbox"/>	<input type="checkbox"/> Constipation
<input type="checkbox"/>	<input type="checkbox"/> Tension	<input type="checkbox"/>	<input type="checkbox"/> Urinary problem	<input type="checkbox"/>	<input type="checkbox"/> Cold sweats
<input type="checkbox"/>	<input type="checkbox"/> Ulcers	<input type="checkbox"/>	<input type="checkbox"/> Fainting	<input type="checkbox"/>	<input type="checkbox"/> Mood swings
<input type="checkbox"/>	<input type="checkbox"/> Buzzing in ears	<input type="checkbox"/>	<input type="checkbox"/> Eyes bothered by light	<input type="checkbox"/>	<input type="checkbox"/> Diarrhea
<input type="checkbox"/>	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/> Stomach upset	<input type="checkbox"/>	<input type="checkbox"/> Dizziness

## Your Wellness History - Health Profile, page 3

### Your Goals

- On a scale of 1 to 10 (1 = none, 10 = extreme), describe your emotional/ psychological/ lifestyle stress levels:

Scale = \_\_\_\_\_ Occupational stress: \_\_\_\_\_

Scale = \_\_\_\_\_ Personal stress: \_\_\_\_\_

- On a scale of 1 to 10 (1 = poor, 10 = excellent), describe your habits and condition as it relates to:

Eating \_\_\_\_\_ Exercise \_\_\_\_\_ Sleep \_\_\_\_\_ General Health \_\_\_\_\_ Wellness lifestyle \_\_\_\_\_

At our office we're concerned about your health and wellness goals. Please take a moment to list your goals

#### Wellness Goals

Be Fit. *(Physical)*

Eat Right. *(Nutritional)*

Think Well. *(Psychological)*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### Please check all that are relevant

Do you:

- Water - Drink 1/2 your body weight in ounces
- Exercise regularly
- Take vitamins or supplements

Would you like to know more about:

- Proper nutrition and meal planning
- Proper exercise routines and techniques
- How to deal with Lifestyle stress

**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 radiographic examination 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: \_\_\_\_\_

Please return this form to our staff and someone will be right with you.



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