



PERSONAL INFORMATION

NAME _____ NAME I PREFER TO BE CALLED _____ DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

AGE _____ HOME PHONE (_____) _____ CELL (_____) _____ WORK (_____) _____

DATE OF BIRTH _____ SOC. SEC. No. _____ - _____ - _____ OCCUPATION _____

E-MAIL ADDRESS (WHOLECARE UPDATES ONLY!) _____

RELATIONSHIP STATUS _____ NUMBER & AGES OF CHILDREN (IF ANY): _____

FOR WOMEN: NO. OF PREGNANCIES: _____ DATE OF LAST MENSTRUAL PERIOD: _____ ARE YOU PREGNANT NOW? YES NO

HOW DID YOU HEAR ABOUT WHOLECARE? WEBSITE MAGAZINE PHONE BOOK FRIEND RELATIVE CO-WORKER

DOCTOR OTHER HEALTH PROVIDER WHO MAY WE THANK FOR REFERRING YOU TO WHOLECARE? _____

CHIEF HEALTH CONCERN

WHAT IS YOUR MAJOR CONCERN? _____

OTHER CONCERNS: _____

HOW LONG HAVE YOU HAD THIS CONDITION? _____ HAVE YOU HAD THIS CONDITION IN THE PAST? _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____

WHAT SEEMS TO MAKE IT BETTER? _____

IS THIS CONDITION PROGRESSIVELY GETTING WORSE? YES NO CONSTANT COMES AND GOES

IS THIS CONDITION INTERFERING WITH YOUR: WORK SLEEP DAILY ROUTINE ENJOYMENT OF LIFE

HOW LONG HAS IT BEEN SINCE YOU *REALLY FELT GOOD*: _____

LIST PREVIOUS DIAGNOSES AND TREATMENTS YOU HAVE RECEIVED FOR PRESENT CONDITION: _____

WHAT DO YOU BELIEVE IS WRONG WITH YOU? _____

FAMILY HEALTH INFORMATION

RELATION:

PAST AND PRESENT HEALTH PROBLEMS:

PERSONAL HISTORY

HAVE YOU RECEIVED CHIROPRACTIC SPINAL ADJUSTMENTS BY A DOCTOR OF CHIROPRACTIC? _____

IF YES, WHEN WAS YOUR LAST VISIT? _____ HOW LONG WERE YOU RECEIVING ADJUSTMENTS? _____

IF YOU STOPPED, WHY DID YOU STOP? _____

WHAT TECHNIQUE(S) WERE USED (IF KNOWN)? _____

DOES ANYONE IN YOUR IMMEDIATE FAMILY RECEIVE CHIROPRACTIC ADJUSTMENTS? _____

HAVE YOU HAD, OR DO YOU RECEIVE ANY OF THE FOLLOWING VEHICLES TOWARD HEALTH, GROWTH, AND DEVELOPMENT? IF YES, PLEASE EXPLAIN WHEN AND ANY COMMENTS YOU WISH TO SHARE:

BODYWORK (MASSAGE, CRANIOSACRAL, ETC.): _____

ACUPUNCTURE: _____ MOVEMENT OR EXERCISE/YOGA: _____

REBIRTHING/BREATHWORK: _____ MEDITATION: _____

PRAYER: _____ PSYCHOTHERAPY: _____

OTHER/COMMENTS: _____

VITAMINS/MINERALS/HERBS/HOMEOPATHICS (PLEASE LIST): _____

WHAT DO YOU HOPE TO RECEIVE FROM CHIROPRACTIC CARE: _____

*The Practice Of Chiropractic Is Based Upon The Location And Adjustment Of Vertebral Subluxations.
Spinal Subluxations Are Caused By Any Stress Your Body Cannot Properly Perceive, Adapt To, Or Recover From.
These Stresses May Be Physical, Chemical, Or Emotional/Mental In Nature.*

BIRTH HISTORY

1. WAS YOUR MOTHER OUTWARDLY ILL PRIOR TO HER PREGNANCY WITH YOU? YES NO

2. WAS YOUR MOTHER TAKING ANY OF THE FOLLOWING PRIOR TO OR DURING HER PREGNANCY WITH YOU? DRUGS ALCOHOL SMOKING

3. DURING YOUR DELIVERY, WAS YOUR MOTHER: CONSCIOUS SEMICONSCIOUS UNCONSCIOUS DON'T KNOW

4. WAS YOUR DELIVERY: DRUG INDUCED FORCEPS OR SUCTION C-SECTION CORD AROUND NECK BREECH
PROLONGED OTHER _____

5. DID YOUR MOTHER SUFFER FROM POST-PARTUM DEPRESSION? YES NO

6. MY BIRTH WAS: AT HOME IN A BIRTHING CENTER IN A HOSPITAL

7. WERE YOU INCUBATED OR ISOLATED AFTER BIRTH? YES NO DON'T KNOW

8. WERE YOU: BOTTLE-FED FORMULA BOTTLE-FED MOTHER'S MILK NURSED NURSED AND BOTTLE-FED

GENERAL PHYSICAL STRESS

9. HAVE YOU (EVEN AS A PASSENGER, EVEN IF YOU DO NOT THINK YOU WERE HURT) BEEN INVOLVED IN A VEHICULAR COLLISION OR NEAR COLLISION?

PLEASE LIST APPROXIMATE DATES AND SEVERITY (MILD, MODERATE OR EXTREME): _____

- 10. WERE YOU EVER KNOCKED UNCONSCIOUS? Yes No
- 11. HAVE YOU EVER USED CRUTCHES, A WALKER, OR A CANE? Yes No
- 12. HAVE YOU EVER BROKEN ANY BONES? Yes No
- 13. HAVE YOU EVER HAD ANY IMPACTS OR FALLS THAT YOU FEEL MAY HAVE INJURED YOUR SPINE? Yes No
- 14. HAVE YOU EVER HAD EXTENSIVE DENTAL WORK DONE? Yes No
- 15. ORTHODONTIC WORK? Yes No

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE (QUESTIONS 10-15) PLEASE EXPLAIN: _____

16. DURING THE DAY I: SIT STAND WALK DESK WORK PHONE WORK DRIVE MECHANICAL WORK HEAVY LIFTING

17. I EXERCISE: DAILY WEEKLY MONTHLY NEVER

18. CHECK IF YOU CURRENTLY HAVE OR HAVE PREVIOUSLY HAD ANY OF THE FOLLOWING CONDITIONS:

- | | | | | | | | | | |
|------------------|--------------------------|----------------|--------------------------|------------------------|--------------------------|----------------------|--------------------------|-------------------|--------------------------|
| ACID REFLUX | <input type="checkbox"/> | DIABETES | <input type="checkbox"/> | HEPATITIS | <input type="checkbox"/> | MULTIPLE SCLEROSIS | <input type="checkbox"/> | SCARLET FEVER | <input type="checkbox"/> |
| ALCOHOLISM | <input type="checkbox"/> | ECZEMA | <input type="checkbox"/> | HIV / AIDS | <input type="checkbox"/> | MUMPS | <input type="checkbox"/> | STROKE | <input type="checkbox"/> |
| ALLERGIES | <input type="checkbox"/> | EMPHYSEMA | <input type="checkbox"/> | IBS | <input type="checkbox"/> | PERTUSSIS | <input type="checkbox"/> | TUBERCULOSIS | <input type="checkbox"/> |
| ANEMIA | <input type="checkbox"/> | EPILEPSY | <input type="checkbox"/> | KIDNEY/BLADDER INFECT. | <input type="checkbox"/> | PNEUMONIA | <input type="checkbox"/> | ULCERS | <input type="checkbox"/> |
| ARTERIOSCLEROSIS | <input type="checkbox"/> | FEVER BLISTERS | <input type="checkbox"/> | MEASLES | <input type="checkbox"/> | POLIO | <input type="checkbox"/> | OTHER CONDITIONS: | _____ |
| ARTHRITIS | <input type="checkbox"/> | GOUT | <input type="checkbox"/> | MIGRAINES | <input type="checkbox"/> | RHEUMATOID ARTHRITIS | <input type="checkbox"/> | | _____ |
| CANCER | <input type="checkbox"/> | HEART DISEASE | <input type="checkbox"/> | MISCARRIAGE | <input type="checkbox"/> | RHEUMATIC FEVER | <input type="checkbox"/> | | _____ |

19. WERE YOU, OR ARE YOU CURRENTLY ACTIVE IN ANY SPORT(S)? Yes No

COMMENTS: _____

20. HAVE YOU BEEN HURT IN ANY OF THESE ACTIVITIES? Yes No

COMMENTS: _____

21. DO YOU READ FOR PROLONGED PERIODS? Yes No

22. DO YOU PLAY A MUSICAL INSTRUMENT? Yes No IF YES, WHAT? _____

23. DO YOU HAVE A PARTICULAR POSITION FOR SLEEPING? Yes No IF YES, WHAT? _____

24. I WEAR: GLASSES BIFOCALS CONTACT LENSES

GENERAL CHEMICAL STRESS

25. ARE YOU CURRENTLY TAKING ANY DRUG (PRESCRIPTION OR OVER-THE-COUNTER) REGULARLY? PLEASE LIST: _____

26. WERE YOU PREVIOUSLY TAKING ANY MEDICATION REGULARLY? PLEASE LIST: _____

27. DO YOU WORK WITH ANY CHEMICALS, FUMES, DUST, POWDER AND/OR SMOKE FOR PROLONGED PERIODS? PLEASE EXPLAIN: _____

MEDICAL TREATMENT

28. HAVE YOU EVER BEEN HOSPITALIZED OR UNDERGONE SURGERY? Yes No IF YES, WHAT WAS DONE TO YOU?

29. HAVE YOU HAD: SPINAL TAP SPINAL INJECTIONS PHYSIOTHERAPY NECK COLLAR SPINAL BRACE TRACTION
HEEL LIFT X-RAY TREATMENTS CORRECTIVE SHOES CORRECTIVE BRACES CHEMOTHERAPY
EXTENSIVE DIAGNOSTIC X-RAYS MAMMOGRAM ENDOSCOPY TRANSFUSION
BREAST AUGMENTATION COLONOSCOPY BONE IN A CAST OR IMMOBILIZATION

RESULTS: _____

SELF ASSESSMENT

30. HOW DO YOU GRADE YOUR PHYSICAL HEALTH? EXCELLENT GOOD FAIR POOR IMPROVING WORSENING
31. HOW DO YOU GRADE YOUR EMOTIONAL/MENTAL HEALTH? EXCELLENT GOOD FAIR POOR IMPROVING WORSENING
32. I HAVE AT LEAST ONE FAMILY MEMBER WITHIN 50 MILES ON WHOM I CAN RELY. ALWAYS SOMETIMES NEVER
33. I HAVE A NETWORK OF FRIENDS AND ACQUAINTANCES. ALWAYS SOMETIMES NEVER
34. I HAVE ONE OR MORE FRIENDS TO CONFIDE IN ABOUT PERSONAL MATTERS. ALWAYS SOMETIMES NEVER
35. I GET STRENGTH FROM MY RELIGIOUS OR SPIRITUAL TRADITIONS AND/OR BELIEFS. ALWAYS SOMETIMES NEVER
36. IF YOU CONSIDER YOURSELF ILL, WHY DO YOU FEEL YOU ARE ILL? _____

37. IF YOU CONSIDER YOURSELF WELL, WHY DO YOU FEEL YOU ARE WELL? _____

38. IS THERE ANYTHING ELSE YOU WISH TO SHARE THAT MAY HELP TO BETTER UNDERSTAND YOU? _____

I hereby authorize *WholeCare* to treat my condition as deemed appropriate through the use of chiropractic manipulation, nutritional therapy, physiotherapy and/or other natural, drug-free methods. I choose to be an active participant in my treatment and realize that I am responsible for my health choices. I understand and agree that I am responsible for payment of *WholeCare* services at the time of my visit *unless* prior arrangements have been made.

PATIENT SIGNATURE _____ DATE: _____

OR, IF APPROPRIATE, PARENT / GUARDIAN SIGNATURE _____

PARENT / GUARDIAN NAME (PLEASE PRINT) _____ DATE: _____