BRIDGEPORT FAMILY CHIROPRACTIC *Where People Come to Stay Well*

NEW PATIENT HEALTH PROFILE

➤ Why This Form Is Important

We are a Maximized Living Chiropractic Office where we focus on your ability to be healthy. Our goals are two-fold. First to address the issues that brought you to our 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.

Date: _____

Name:_____ Age:_____ Birth date:_____ ☐ Male ☐ Female

Address:_____ City:_____ Postal Code:_____

Home Phone:_____ Work Phone:_____ Mobile Phone: _____

Email Address: _____

Occupation:_____ Employer: _____

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Spouse's Name:_____ Spouse's Occupation: _____

Number of Children:_____ Names: _____

Reason for consulting Bridgeport Family Chiropractic: _____

Who may we thank for referring you to our office: _____

➤ Your Health Profile

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.

The Beginning Years (to age 17)	YES	NO	UNSURE
Did you have any childhood illnesses?	☐	☐	☐
Did you have a serious fall as a child?	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take or use any drugs?	☐	☐	☐
Did you have any surgery?	☐	☐	☐
Have you ever fallen or jumped from a height over three feet? i.e. crib, bunk bed, trees …	☐	☐	☐
Were you involved in any car accidents as a child?	☐	☐	☐
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 (age 18 to present)	YES	NO
Do/did you smoke?	☐	☐
Do/did you drink alcohol?	☐	☐
Have you been in any accidents?	☐	☐
Have you had any surgery?	☐	☐
Do/did you play adult sports?	☐	☐
Do/did you participate in extreme sports?	☐	☐

On a scale of 1 to 10 describe your stress level:
(1 = none / 10 = extreme)

Occupational:_____ Personal: _____

On a scale of Poor, Good or Excellent describe your:

Diet:_____ Exercise: _____

Sleep:_____ General Health: _____

Please add any pertinent comments: _____

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➤ Addressing the issues that have brought you to Bridgeport Family Chiropractic

If you have no symptoms or complaints, and are here for wellness services please check here ☐ to indicate **"I Wish to have Chiropractic Wellness Services"** and skip to section **B – Family Health Profile**.

For all others, please briefly describe your main area complaint, including the effect it has on your life:

_____

_____

A. Personal Health History

If you are experiencing pain, you would describe it as (check all that apply):

☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

Since the problem started, it is… ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse: _____

The problem interferes with (check all that apply): ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

Health Care professionals you have seen for this problem (please list):

☐ Chiropractor_____ ☐ Medical Doctor_____ ☐ Other _____

Please share any details: _____

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 stiffness	☐ Cold hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot flashes
☐ Cold sweats	☐ Lights bother eyes	☐ Problem urinating	☐ Heartburn
☐ Mood swings	☐ Menstrual pain	☐ Menstrual irregularity	☐ Ulcers

List any medications you are taking:

_____

B. Family Health Profile

At Bridgeport Family Chiropractic we are not only interested in your health and well-being, but also your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____ Mother _____

Spouse _____ Father _____

Siblings _____ Others _____

Do you believe: 1) Exercise is necessary for good health? ☐ Yes ☐ No 2) Diet affects your health? ☐ Yes ☐ No 3) Vitamins or supplements are necessary? ☐ Yes ☐ No

The statements on this form are accurate to the best of my recollection and I agree to allow Bridgeport Family Chiropractic to examine me for further evaluation.

Signature:_____ Date: _____