Harrison Chiropractic & Wellness

2828 West 4700 South Suite A · Taylorsville UT 84118

(801)966-3101 · Fax (801)966-0161

PERSONAL INFORMATION:

Name: _____ Date: _____

Address: _____ City: _____ State: ____

Zip: _____ Male: _____ Female: _____ Single Married Divorced Widowed

Your DOB: _____ Age: _____ Spouses Name: _____

Home Phone(_____)_____-_____ Work Phone(_____)_____-_____

Cell Phone (_____) _____-_____ Can we text you at this number? Yes No

Email Address: _____ Referred By: _____

# of Children, Names and Ages:_____

Occupation: _____ Employer Name: _____

Primary Insurance:_____ Policy Holder: _____

Insured DOB: _____ Insured Employer Name: _____

YOUR HEALTH:

Please place an X on the scale marking where you believe your level of health and wellness is at this time. Place a circle (o) on the diagram indicating where you would like your health and wellness to be.

0-59	60-69	70-79	80-89	90-100
Very Challenged	Challenged	Transition	Good	Excellent

YOUR HEALTH PROFILE:

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or complaints and are here for Chiropractic Wellness Services please skip to the General History page.

_____
_____
_____

Rate the severity from 1-10 _____

When did this start? _____

Are the symptoms constant or intermittent?

Did this problem begin with an injury, if so what kind _____

Since the problem started, it is _____The Same _____Getting Better _____Getting Worse

What makes the problem worse?_____

What, if anything makes it feel better? _____

Does this interfere with your: _____Work _____Leisure _____Sleep _____Sports _____
Other:_____

Have you seen other doctors for this condition? ____Chiropractor ____Medical Dr. ____Other

Name/ Address: _____
Date: _____ What was the diagnosis? _____

Name/ Address: _____
Date: _____ What was the diagnosis? _____

General History:

List all medications you are taking and why: (Prescription and non-prescription)

_____
_____

Have you had any surgeries or hospitalizations? (Please include all surgeries)

_____
_____
_____

What do you do for a living? _____

Have you ever had any work related injuries? _____

Have you ever had any slips, falls or Auto Accidents?

_____
_____

Please check (✓) symptoms you have had in the last 6 months, even if they do not seem related to your current problem:

__ Headaches __ Pins and needles in legs __ Fainting __ Neck pain __ Fatigue

__ Loss of Smell __ Pins and needles in arms __ Back Pain __ Loss of balance __ Urinary Problem

__ Dizziness __ Numbness in fingers __ Buzzing in ears __ Nervousness __ Irritability

__ Loss of taste __ Numbness in toes __ Upset Stomach __ Heartburn __ Constipation

__ Diarrhea __ Sleeping problems __ Tension __ Stiff Neck __ Depression

__ Cold Hands __ Cold Feet __ Ringing in ears __ Lights bother eyes __ Fever

__ Ulcers __ Menstrual Irregularity __ Hot Flashes __Cold Sweats __ Mood Swings

__ Menstrual Pain

On a scale of 1-10 describe your psychological/emotional stress levels: (1= none - 10=extreme)
Occupational: _____ Personal: _____

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:
Eating habits: _____ Exercise habits:_____ Sleep: _____ General Health: _____ Mind-set:_____

YOUR GOALS:

At our office we concern ourselves with YOUR health and YOUR wellness goals.
Please list your goals for your health and wellness in the spaces provided.

Physical Goals	Nutritional/ Biochemical Goals	Psychological Goals
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever:

Bought bottled water: ___Yes ___No
Belonged to a health club: ___Yes ___No
Consumed vitamins or supplements ___Yes ___No
If there is a need for dietary changes would you like to know? ___Yes ___No
If there is a need for specific exercises would you like to know? ___Yes ___No
If there is a need for support in the psychological/mind/body/stress dimension of health would you like assistance? ___Yes ___No
Do you smoke ___Yes ___ No
Do you drink alcohol ___Yes ___ No

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature_____ Date: _____

Thank you for filling out this form. It is your first step to creating wellness!