T 1 2 3 ______ In

EVOLVE Chiropractic Health Profile

Name_________________________________Date____/____/____Age______ Male/Female

Address_____________________________City__________________State_____Zip________

Phone: Home________________ Cell________________Date of Birth______/______/______

Who may we thank for referring you? _________________Email Address__________________

Occupation_______________________ Employer's Name______________________________

Single / Married / Divorced / Widowed Spouse's Name______________________

Number of Children______ Names, Ages & Gender____________________________________

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LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. ____________________	__________	_____________	_______________	_______________	___________
2. ____________________	__________	_____________	_______________	_______________	___________
3. ____________________	__________	_____________	_______________	_______________	___________
4. ____________________	__________	_____________	_______________	_______________	___________
5. ____________________	__________	_____________	_______________	_______________	___________

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR? _______________ MEDICAL DOCTOR_______________OTHER_________________

WHO AND WHEN?____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

DIZZINESS	***THROAT ISSUES***	***KIDNEY PROBLEMS***	***LIVER DISEASE***	***NERVOUSNESS***
HEADACHES	***THYROID PROBLEMS***	***MID BACK PAIN***	***SHOULDER PAIN***	***EPILEPSY***
VERTIGO	***ASTHMA***	***IRRITABLE BOWEL***	***CHRONIC FATIGUE***	***DISC PROBLEM***
EAR INFECTIONS	***ULCERS***	***SCIATICA***	***LUPUS***	***INFERTILITY***
NAUSEA	***NUMBNESS IN ARMS***	***NUMBNESS IN LEGS***	***FIBROMYALGIA***	***GASTRIC REFULX***
TMJ	***NUMBNESS IN HANDS***	***NUMBNESS IN FEET***	***CHEST PAIN***	***BLADDER PROBLEMS***
NECK PAIN	***MENSTRUAL DISORDER***	***LOW BACK PAIN***	***ARM PAIN***	***CHRONIC SINUS***
MIGRAINES	***HEART DISORDERS***	***HIP PAIN***	***ADD/ADHD***	***OTHER***___________
ANXIETY	***STOMACH DISORDERS***	***LEG PAINS***	***KNEE PAIN***	_________________

CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD:

STROKE	CANCER	HEART DISEASE	SPINAL SURGERY	SEIZURES	SPINAL BONE FRACTURE	SCOLIOSIS	DIABETES

Consultation Completed By: ______ Evaluation Cost (If Applicable): ______

LIST ALL SURGICAL OPERATIONS AND YEARS ____

____

LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON:

____

____

WHEN WAS YOUR LAST AUTO ACCIDENT____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO

IF YOU HAVE, DR. & DATE____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE____

OTHER TRAUMA: ____

SOCIAL HISTORY

1. SMOKING: ❑cigars ❑ pipe ❑ cigarettes → How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

2. EXERCISE: How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

3. How does your present problem affect the following: **HOBBIES – RECREATIONAL ACTIVITIES - EXERCISE**

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4. WHAT DAILY ACTIVITIES ARE BEING RESTRICTED BY YOUR CURRENT HEALTH PROBLEMS:

Carrying/Lifting Groceries	Driving	Reading/Concentration	Sexual Activities
Sitting to Standing	Extended Computer Use	Sweeping/Vacuuming	Sleep
Climbing Stairs	Garbage	Dressing	Static Sitting
Pet Care	Lifting Children	Shaving	Static Standing
Yard Work	Walking	Bathing	
Laundry	Dishes		

Other: ____

*__PLEASE MARK__ the areas on the Diagram with the following **letters** to describe your symptoms:

R = Radiating **B = B**urning **D = D**ull **A =** Aching **N = N**umbness
S = Sharp/ **S**tabbing **T= T**ingling

What relieves your symptoms? ______________________________

What makes them feel worse? ______________________________