

Personal Health Profile

Name	Date	Date of Birth	Weight	Height	Age	Marital status																											
Occupation		Number of children and ages		Name of Spouse																													
Referred by	Date problem started	Describe current problem																															
Other doctors seen for this problem		Have you had this problem before? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe below:																															
Diagnosis																																	
Does your present complaint involve any of the following: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Dizziness</td> <td><input type="checkbox"/> Pain between shoulders</td> <td><input type="checkbox"/> Visual disturbance</td> </tr> <tr> <td><input type="checkbox"/> Earaches</td> <td><input type="checkbox"/> Hip pain R/L</td> <td><input type="checkbox"/> Pain in abdomen</td> </tr> <tr> <td><input type="checkbox"/> Ringing in ears</td> <td><input type="checkbox"/> Thigh pain R/L</td> <td><input type="checkbox"/> Stomach nausea</td> </tr> <tr> <td><input type="checkbox"/> Fainting</td> <td><input type="checkbox"/> Calf pain R/L</td> <td><input type="checkbox"/> Vomiting</td> </tr> <tr> <td><input type="checkbox"/> Headaches</td> <td><input type="checkbox"/> Foot pain R/L</td> <td><input type="checkbox"/> Gas</td> </tr> <tr> <td><input type="checkbox"/> Poor appetite</td> <td><input type="checkbox"/> Numbness or tingling in leg/foot R/L</td> <td><input type="checkbox"/> Indigestion</td> </tr> <tr> <td><input type="checkbox"/> Shoulder/arm pain R/L</td> <td><input type="checkbox"/> Sinus trouble</td> <td><input type="checkbox"/> Diarrhea</td> </tr> <tr> <td><input type="checkbox"/> Numbness/tingling in shoulder/arm R/L</td> <td><input type="checkbox"/> Sore throat</td> <td><input type="checkbox"/> Constipation</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Pain across belt line</td> </tr> </table>							<input type="checkbox"/> Dizziness	<input type="checkbox"/> Pain between shoulders	<input type="checkbox"/> Visual disturbance	<input type="checkbox"/> Earaches	<input type="checkbox"/> Hip pain R/L	<input type="checkbox"/> Pain in abdomen	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Thigh pain R/L	<input type="checkbox"/> Stomach nausea	<input type="checkbox"/> Fainting	<input type="checkbox"/> Calf pain R/L	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Headaches	<input type="checkbox"/> Foot pain R/L	<input type="checkbox"/> Gas	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Numbness or tingling in leg/foot R/L	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Shoulder/arm pain R/L	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Numbness/tingling in shoulder/arm R/L	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Constipation			<input type="checkbox"/> Pain across belt line
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Pain between shoulders	<input type="checkbox"/> Visual disturbance																															
<input type="checkbox"/> Earaches	<input type="checkbox"/> Hip pain R/L	<input type="checkbox"/> Pain in abdomen																															
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Thigh pain R/L	<input type="checkbox"/> Stomach nausea																															
<input type="checkbox"/> Fainting	<input type="checkbox"/> Calf pain R/L	<input type="checkbox"/> Vomiting																															
<input type="checkbox"/> Headaches	<input type="checkbox"/> Foot pain R/L	<input type="checkbox"/> Gas																															
<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Numbness or tingling in leg/foot R/L	<input type="checkbox"/> Indigestion																															
<input type="checkbox"/> Shoulder/arm pain R/L	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Diarrhea																															
<input type="checkbox"/> Numbness/tingling in shoulder/arm R/L	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Constipation																															
		<input type="checkbox"/> Pain across belt line																															
What position, movement, or activity makes this worse?																																	
What do you do, take, or put on this that helps?																																	
Do you have regular troubles with: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Your present complaint</td> <td><input type="checkbox"/> Eyes</td> <td><input type="checkbox"/> Nervous stomach</td> </tr> <tr> <td><input type="checkbox"/> Headaches</td> <td><input type="checkbox"/> Lower back pain</td> <td><input type="checkbox"/> Bladder infections</td> </tr> <tr> <td><input type="checkbox"/> Neck pain</td> <td><input type="checkbox"/> Shoulder pain R/L</td> <td><input type="checkbox"/> Menstrual cramping or irregularity</td> </tr> <tr> <td><input type="checkbox"/> Sinus trouble</td> <td><input type="checkbox"/> Between shoulder pain</td> <td><input type="checkbox"/> Constipation</td> </tr> <tr> <td><input type="checkbox"/> Sore throat</td> <td><input type="checkbox"/> Arm pain R/L</td> <td><input type="checkbox"/> Diarrhea</td> </tr> <tr> <td><input type="checkbox"/> Canker sores</td> <td><input type="checkbox"/> Hand pain R/L</td> <td><input type="checkbox"/> Hemorrhoids</td> </tr> <tr> <td><input type="checkbox"/> Deafness</td> <td><input type="checkbox"/> Hip pain R/L</td> <td><input type="checkbox"/> High or low blood pressure</td> </tr> <tr> <td><input type="checkbox"/> Dizziness</td> <td><input type="checkbox"/> Leg pain R/L</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Earaches</td> <td><input type="checkbox"/> Acid stomach</td> <td></td> </tr> </table>							<input type="checkbox"/> Your present complaint	<input type="checkbox"/> Eyes	<input type="checkbox"/> Nervous stomach	<input type="checkbox"/> Headaches	<input type="checkbox"/> Lower back pain	<input type="checkbox"/> Bladder infections	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Shoulder pain R/L	<input type="checkbox"/> Menstrual cramping or irregularity	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Between shoulder pain	<input type="checkbox"/> Constipation	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Arm pain R/L	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Canker sores	<input type="checkbox"/> Hand pain R/L	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Deafness	<input type="checkbox"/> Hip pain R/L	<input type="checkbox"/> High or low blood pressure	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Leg pain R/L		<input type="checkbox"/> Earaches	<input type="checkbox"/> Acid stomach	
<input type="checkbox"/> Your present complaint	<input type="checkbox"/> Eyes	<input type="checkbox"/> Nervous stomach																															
<input type="checkbox"/> Headaches	<input type="checkbox"/> Lower back pain	<input type="checkbox"/> Bladder infections																															
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Shoulder pain R/L	<input type="checkbox"/> Menstrual cramping or irregularity																															
<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Between shoulder pain	<input type="checkbox"/> Constipation																															
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Arm pain R/L	<input type="checkbox"/> Diarrhea																															
<input type="checkbox"/> Canker sores	<input type="checkbox"/> Hand pain R/L	<input type="checkbox"/> Hemorrhoids																															
<input type="checkbox"/> Deafness	<input type="checkbox"/> Hip pain R/L	<input type="checkbox"/> High or low blood pressure																															
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Leg pain R/L																																
<input type="checkbox"/> Earaches	<input type="checkbox"/> Acid stomach																																
Have you ever had: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Stroke/TIA</td> <td><input type="checkbox"/> Ulcers</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Kidney infections</td> <td><input type="checkbox"/> Pneumonia</td> </tr> <tr> <td><input type="checkbox"/> Heart trouble</td> <td><input type="checkbox"/> MS</td> <td></td> </tr> </table>							<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney infections	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> MS																			
<input type="checkbox"/> Cancer	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Ulcers																															
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney infections	<input type="checkbox"/> Pneumonia																															
<input type="checkbox"/> Heart trouble	<input type="checkbox"/> MS																																
When did you last visit a: <table style="width:100%; border:none;"> <tr> <td>Dentist</td> <td><input type="checkbox"/> Within 1 year</td> <td><input type="checkbox"/> When _____</td> </tr> <tr> <td>Family doctor</td> <td><input type="checkbox"/> Within 1 year</td> <td><input type="checkbox"/> When _____</td> </tr> <tr> <td>Eye doctor</td> <td><input type="checkbox"/> Within 1 year</td> <td><input type="checkbox"/> When _____</td> </tr> <tr> <td>Chiropractor</td> <td><input type="checkbox"/> Within 1 year</td> <td><input type="checkbox"/> Who _____</td> </tr> </table> Last X-rays taken (when/why): _____ _____ _____							Dentist	<input type="checkbox"/> Within 1 year	<input type="checkbox"/> When _____	Family doctor	<input type="checkbox"/> Within 1 year	<input type="checkbox"/> When _____	Eye doctor	<input type="checkbox"/> Within 1 year	<input type="checkbox"/> When _____	Chiropractor	<input type="checkbox"/> Within 1 year	<input type="checkbox"/> Who _____															
Dentist	<input type="checkbox"/> Within 1 year	<input type="checkbox"/> When _____																															
Family doctor	<input type="checkbox"/> Within 1 year	<input type="checkbox"/> When _____																															
Eye doctor	<input type="checkbox"/> Within 1 year	<input type="checkbox"/> When _____																															
Chiropractor	<input type="checkbox"/> Within 1 year	<input type="checkbox"/> Who _____																															
List past surgeries or serious illnesses and date: _____ _____ _____ List past broken bones and date: _____ _____ _____ List past auto accidents or serious falls and date: _____ _____ _____ List medications you take now or in the past: _____ _____ _____																																	
Are you currently pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure Do you currently: <table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Smoke _____, packs per day</td> <td><input type="checkbox"/> Use narcotics</td> </tr> <tr> <td><input type="checkbox"/> Consume alcohol, <input type="checkbox"/> Frequently</td> <td><input type="checkbox"/> Infrequently</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> I have the following conditions (not listed above): _____</td> </tr> <tr> <td colspan="2">_____</td> </tr> <tr> <td colspan="2">_____</td> </tr> <tr> <td colspan="2"><input type="checkbox"/> These are true answers of myself, _____</td> </tr> </table>							<input type="checkbox"/> Smoke _____, packs per day	<input type="checkbox"/> Use narcotics	<input type="checkbox"/> Consume alcohol, <input type="checkbox"/> Frequently	<input type="checkbox"/> Infrequently	<input type="checkbox"/> I have the following conditions (not listed above): _____		_____		_____		<input type="checkbox"/> These are true answers of myself, _____																
<input type="checkbox"/> Smoke _____, packs per day	<input type="checkbox"/> Use narcotics																																
<input type="checkbox"/> Consume alcohol, <input type="checkbox"/> Frequently	<input type="checkbox"/> Infrequently																																
<input type="checkbox"/> I have the following conditions (not listed above): _____																																	

<input type="checkbox"/> These are true answers of myself, _____																																	

My activity is restricted: (mark on line below)

No _____ Bed Ridden

Today my pain is: (mark on line below)

No _____ Unbearable Pain

Please mark on the drawings the location of your complaint.

