UNDERSTANDING YOUR HEALTH HISTORY

Please check (√) all symptoms you have ever had, even if they do not seem related to your current condition.

□ Headaches	□ Kidney/Bladder	□ Hepatitis
□ Pins and Needles in arms	□ Neurological	□ HIV
□ Dizziness	□ Osteoporosis	□ Psoriasis/Eczema
□ Numbness in fingers	□ Liver Disease	□ Anemia
□ Fatigue	□ Bleeding Disorder	□ Arthritis
□ Sleeping problems	□ Diabetes	□ Accident - Major
□ Diarrhea	□ Thyroid	□ High Cholesterol
□ Cold Sweats	□ Alcohol or drug abuse	□ Lung Disease
□ Mood Swings	□ Mental Health	□ Stomach Ulcer

Family Health Profile:
At Advanced Spine Center we are not only interested in your health, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____
Spouse _____
Mother _____
Father _____
Brothers _____
Sisters _____
Others _____

Have you ever:

Bought bottled water:	□ Yes, currently	□ Yes, in the past	□ No, never
Belonged to a health club / gym?	□ Yes, currently	□ Yes, in the past	□ No, never
Consumed Vitamins or supplements:	□ Yes, currently	□ Yes, in the past	□ No, never

YOUR HEALTH PROFILE

why this section is important: As a Wellness Center, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this 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.

Please answer the following questions the best you can:

YOUR CHILDHOOD YEARS:

Did you have any childhood injures?	Yes	No	Unsure	Did you suffer any other traumas (physical or emotional)	Yes	No	Unsure
Did you have any serious falls as a child?	Yes	No	Unsure	Were you vaccinated?	Yes	No	Unsure
Did you play youth sports?	Yes	No	Unsure	As a child, were you under regular Chiropractic care?	Yes	No	Unsure
Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed , trees)	Yes	No	Unsure	Did you have any surgery?	Yes	No	Unsure
Was there any prolonged use of medicine such as antibiotics or an inhaler?	Yes	No	Unsure	Were involved in any other accidents as a child?	Yes	No	Unsure
Did you take /use any drugs?	Yes	No	Unsure	Did you have a difficult or traumatic birth?	Yes	No	Unsure

You're almost done, just one more page!