OFW CHIROPRACTIC
30 Harrington Ave
Westwood, NJ 07675
201-664-6000

Personal Information

NAME: _____ AGE: DATE: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

E-MAIL ADDRESS: _____ ☐ Male ☐ Female

BIRTH DATE: _____ BEST TIME & NO. TO CONTACT: _____

OCCUPATION: _____ EMPLOYER: _____

SS NO.: _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Your Health Profile

Why this Form is Important

Our goals are to first address the issues that brought you to our office and second to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, bio-chemical and psychological/emotional stresses that can accumulate over time and result in serious loss of your health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses, past and present, that you face and allow us to better assess the challenges to your overall potential.

Addressing the Issues that Brought You to Our Office

If you have no symptoms or complaints and you are here for **Chiropractic Wellness Services**, please skip to the "General History". (Next Page)

Please briefly list your Health Concerns:

Health Concern: List Your Concerns According to their severity	Rate Severity 1= Mild 10=unbearable	When did this episode start?	If you had the condition before, when?	Did problem begin with An injury?	Are symptoms constant?
1.					
2.					
3.					
4.					

In the same order as above, please describe the ***quality*** of each Health Concern (sharp, dull, throbbing, burning, numbness, tingle, radiating, etc.):

1. _____
2. _____
3. _____
4. _____

Please briefly describe details of your **Chief Complaint, including how it started and the effect it has had on your life.**

_____

_____

_____

_____

Since your problem started, it is . . . ☐ About the same ☐ Getting Better ☐ Getting Worse

What makes it feel worse? _____

What makes it feel better? _____

_____

What have you tried to relieve pain? Did it help? _____

_____

I ☐ do ☐ do not have a family history of this or similar symptoms (if you do, please describe) _____

_____

_____

This condition is interfering with my ☐ work ☐ leisure ☐ sleep ☐ sports/exercise/walking ☐ positive attitude ☐ hobbies ☐ other _____

Have you had to, or felt the need to make any "positive" changes in your lifestyle due to your condition? (i.e.: eat better, less alcohol or drugs, meditate, less destructive sports, activities, etc.) If so, what? _____

_____

_____

_____

Other doctors you've seen for this condition: ☐ chiropractor ☐ medical ☐ other _____

1. Name/Address: _____

   Date: _____ Diagnosis: _____

   Tests/Treatment: _____

2. Name/Address: _____

   Date: _____ Diagnosis: _____

   Tests/Treatment: _____

General History:

Please check **all** symptoms you **have ever** experienced, even if they do not seem related to your current problem:

☐ Headaches	☐ Pins/Needles in legs	☐ Fainting	☐ Neck pain
☐ Pins & needles in arm	☐ 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 upsets
☐ Fatigue	☐ Depression	☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Stiff neck	☐ Cold hands	☐ Cold feet
☐ Diarrhea	☐ Constipation	☐ Fever	☐ Hot flashes
☐Cold sweats	☐ Lights bother eyes	☐ Urinary problems	☐ Heartburn
☐ Mood swings	☐Menstrual pain	☐ Menstrual irregularity	☐ Ulcers

List any medications you are taking and why: **(prescription and non-prescription)** _____

_____

_____

Have you had any surgery? (Please include all procedures, childhood and adult. Use back of page, if necessary)

1. Type _____ Date: _____ Dr. _____
2. Type _____ Date: _____ Dr. _____
3. Type _____ Date: _____ Dr. _____
4. Type _____ Date: _____ Dr. _____
5. Type _____ Date: _____ Dr. _____

Accidents, falls and/or injuries: (Childhood or adult, auto, work, personal) Check those related to your **Present** condition:

1. Type _____ Date: _____ Hosp.: ☐ Yes / ☐ No ☐ Present
2. Type _____ Date: _____ Hosp.: ☐ Yes / ☐ No ☐ Present
3. Type _____ Date: _____ Hosp.: ☐ Yes / ☐ No ☐ Present
4. Type _____ Date: _____ Hosp.: ☐ Yes / ☐ No ☐ Present

Have you ever had any x-rays, MRIs, or CT scans? (Please use back of page, if necessary)

1. Type: _____ Body Part: _____ Date: _____ Facility: _____
2. Type: _____ Body Part: _____ Date: _____ Facility: _____
3. Type: _____ Body Part: _____ Date: _____ Facility: _____
4. Type: _____ Body Part: _____ Date: _____ Facility: _____
5. Type: _____ Body Part: _____ Date: _____ Facility: _____

Do you wear orthotics or a heel lift? ☐ Yes / ☐ No Please specify: _____

Stress plays a major role in causing the conditions we see in this office. To more completely help you please indicate the top three of the stresses in your life for each category:

1. Physical stress (accidents, falls, injuries, work, repetition, posture, etc.)
   a. _____
   b. _____
   c. _____
2. Bio-chemical stress (smoke, unhealthy food, missed meals, not enough water, drugs, etc.)
   a. _____
   b. _____
   c. _____
3. Psychological (emotional, work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____
   c. _____

The Beginning Years

Research is showing that many health issues that occur as an adult originated during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Birth to 17 years of age	**Yes**	**No**	**Unsure**
Did you ever have any serious childhood illnesses	☐	☐	☐
Did you have any serious falls as a child	☐	☐	☐
Did you play youth sports?	☐	☐	☐
Did you take / use any drugs (prescription or not)?	☐	☐	☐
Were any drugs used over prolonged time such as antibiotics or inhalers?	☐	☐	☐
Did you suffer any other physical traumas?	☐	☐	☐
Did you suffer any other emotional traumas?	☐	☐	☐
Were you vaccinated?	☐	☐	☐
Were you under regular chiropractic care?	☐	☐	☐

Adult (18 to present)

	Yes	No
Did/Do you smoke?	☐	☐
Did/Do you drink alcohol more than socially?	☐	☐
Did/Do you play any sports?	☐	☐
Did/Do you play any extreme sports?	☐	☐
Have you had regular chiropractic care?	☐	☐

On a scale of 1-10, where 1 is none and 10 is extreme; please describe your psychological/emotional stress levels: Occupational: _____ Personal : _____

On a 1-10 scale, where 1 is very poor and 10 is excellent; please describe the following:

Eating Habits: _____ Exercise Habits: _____ Sleep: _____

General Health: _____ Mind-Set/Positive Attitude: _____

Do you sleep soundly? Currently: ☐ Yes ☐ No; Typically: ☐ Yes ☐ No

In what position do you typically sleep? _____

Describe your pillow: _____ Is it comfortable? ☐ Yes ☐ No

Family Health Profile

In our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please list below their names and any health or concerns they may have:

Spouse: _____

Children: _____

_____

Mother: _____

Father: _____

Siblings: _____

_____

Have you ever:	**Yes**	**No**	**Currently**
Bought bottled water?	☐	☐	☐
Belonged to a health club/gym?	☐	☐	☐
Consumed vitamins or supplements?	☐	☐	☐
Considered dietary changes, if you thought it would make a difference?	☐	☐	☐
Considered adding/changing exercises, if you thought it would help you?	☐	☐	☐
Considered improving your mind-body or psychological stress?	☐	☐	☐

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 services rendered is due at the time of service.

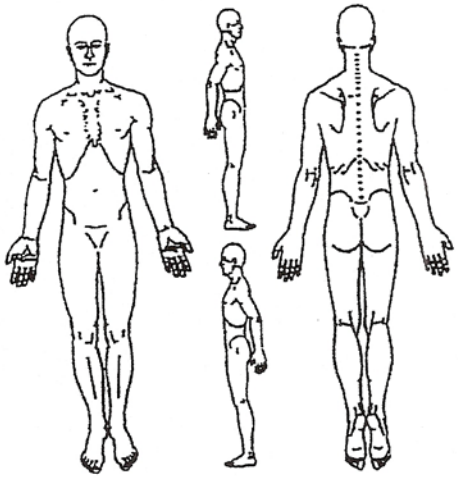
Signature: _____ Date: _____

Thank you for filling out this form completely. It is your first step to Maximizing Your Potential!

Return this to our front desk staff and the doctor will be right with you.

USE THE LETTERS LISTED BELOW TO INDICATE
THE *TYPE* AND *LOCATION* OF YOUR PAIN & SENSATIONS

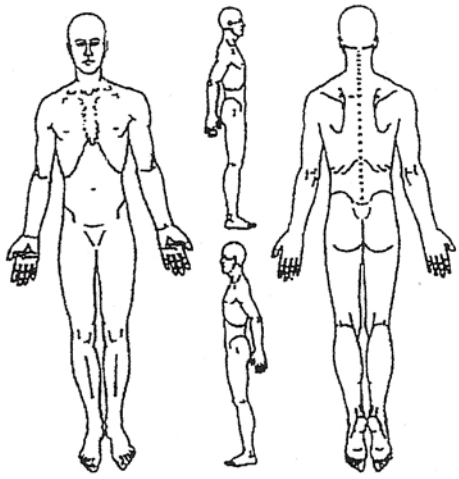
A = ACHE	B = BURNING	S = STABBING
N = NUMBNESS	P = PINS & NEEDLES	O = OTHER



COMMENTS: _____

_____

PT INITIALS _____ DATE _____



COMMENTS: _____

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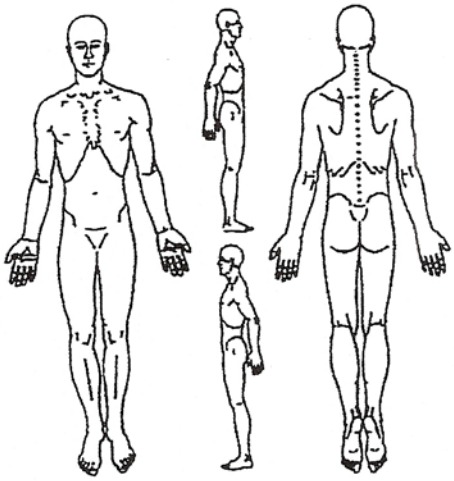
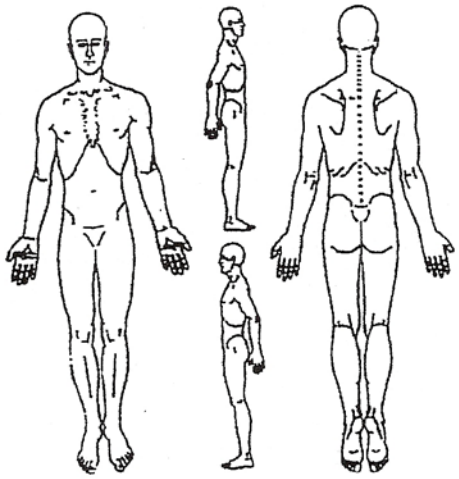
PT INITIALS _____ DATE _____



COMMENTS: _____

_____

PT INITIALS _____ DATE _____



COMMENTS: _____

_____

PT INITIALS _____ DATE _____

Examiner: _____

Comments: _____