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WELCOME TO OUR OFFICE. THIS HEALTH PROFILE IS INTENDED TO HELP US WORK TOGETHER TO ADDRESS YOUR ISSUES.

PATIENT INFORMATION		
Name *(First Last)*:	◉ M ○ F	**DOB:**
Address:		
Email:		
How did you hear about us?		
Primary phone:	**Occupation:**	
Today's date:	**Reason for visit:**	

REVIEW OF CURRENT SYMPTOMS
Describe your symptoms:
What caused your present symptoms (if known) and when did they begin?
Symptoms are located: ☐ right side ☐ left side ☐ front ☐ midline ☐ back
Symptoms are: ○ occasional ○ intermittent ○ frequent ○ constant
Level of discomfort: low ◉ ○ ○ ○ ○ ○ ○ ○ ○ ○ severe
What treatments have you tried to resolve your symptoms?
What helps/makes you feel better?
What hurts/makes you feel worse?

HEALTH HISTORY
Previous Medical Conditions & Dates
Previous Traumas (fractures, car accidents, etc.) & Dates
Previous Surgeries & Dates
Family/Hereditary Health Issues

CURRENT HEALTH STATUS		
Exercise	Frequency**:**	
	Activities**:**	
Medication	Name	Reason

Systemic/underlying health conditions:

Medical problems diagnosed by other doctors:

Constitutional Health lack of energy, unexplained weight loss/weight loss, change in appetite, fever, night sweats	☐ **No**	☐ **Yes**	**Describe:**
Ears, Nose, Mouth, Throat difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain, numbness	☐ **No**	☐ **Yes**	**Describe:**
Cardiovascular/Circulatory bruising, slow clotting, irregular heartbeat, racing heart, chest pains, swelling in extremities	☐ **No**	☐ **Yes**	**Describe:**
Respiratory shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray	☐ **No**	☐ **Yes**	**Describe:**
Gastrointestinal heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence	☐ **No**	☐ **Yes**	**Describe:**
Genitourinary bladder condition/symptoms, prostate condition, decrease in desire, infertility	☐ **No**	☐ **Yes**	**Describe:**
Musculoskeletal joint pain, muscle weakness, decreased range of motion, disc injury, scoliosis, stenosis, neuropathy	☐ **No**	☐ **Yes**	**Describe:**
Integumentary rash, itching, skin lesion, hair loss, change in skin tone	☐ **No**	☐ **Yes**	**Describe:**
Neurologic headaches, visual changes, weakness, sensory changes, numbness/tingling, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions	☐ **No**	☐ **Yes**	**Describe:**
Psychiatric irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, addiction	☐ **No**	☐ **Yes**	**Describe:**
Endocrine intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive	☐ **No**	☐ **Yes**	**Describe:**
Immunologic autoimmune disease, seasonal allergies, systemic itching, frequent infections	☐ **No**	☐ **Yes**	**Describe:**

Office use: ☐ FS
☐ PM
☐ SCAN