PRECISE MOVES CHIROPRACTIC AND HEALING CENTER WELLNESS FORM
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First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: ____ Email address: _____

Occupation: _____ Home Phone: _____

Employer: _____ Cell Phone: _____

Kids and ages: _____ Height: _____ Weight: _____

How did you hear about our office? _____

HEALTH INFORMATION:

What brings you into our office? If you have no complaints and are coming in for wellness, please check here ❑

If coming in with a physical symptom, briefly explain why you are coming in to see us:

_____

_____

If you have a symptom, does your it interfere with: Work ❑ Sleep ❑ Walking ❑ Hobbies ❑ Family Enjoyment ❑ Other ❑ _____

Where would you rank your health on a health scale:

Exellent ❑	Very Good ❑	Good ❑	Transitional ❑	Challanged ❑	Very Challanged ❑
95-100%	90-94%	80-89%	70-79%	60-69%	0-59%

What other professionals do you currently see for your health care? ❑ Massage Therapist ❑ Acupuncturist ❑ Naturopath ❑ Homeopath ❑ Medical Doctor ❑ Other _____

Have you had previous chiropractic care? If yes, when and for what goal? _____

Please list any surgeries and dates:_____

_____

Please list any medications you are taking:_____

_____

LIFESTYLE INFORMATION:

Do you exercise? ❑ Yes ❑ No If yes, what type, how much and how often?_____

Do you smoke? ❑ Yes ❑ No If yes, how much? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much and how often?_____

Do you drink water? ❑ Yes ❑ No If yes, how much and how much per day? _____

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HEALTH HISTORY:

Please circle all of the following health concerns that you have experienced in the past or present, even if you think it does not relate to your present health concern. **Please mark an Y for past and X for present.**

Allergies	Anxiety	Immune System Issues
Arthritis	Asthma	Back Problem
Bladder Problems	Cancer	Circulatory disorder
Depression	Diarrhea	Constipation
Digestive Problems	Dizziness	Headaches
Heartburn	Reflux	Fatigue
Kidney Disease	Menstrual Cramps	Mood Swings
Neck dysfunction	Numbness/Tingling	Osteoporosis
Sinus Trouble	Low back pain	Skin Conditions
Urinary Difficulty	Heart Condition	Vertigo
Difficulty sleeping	Shoulder pain	Foot pain
Loss of balance	Liver problems	Other:

STRESS HISTORY:

Please circle whether you have ever experienced stress in the following areas. Your answers enable us to determine which factors have contributed to your present health concerns.

1) **Childhood**:

Car Accident	Inhaler use	Surgery
Vaccination	Sports	Head Trauma
Childhood Illness	Prescription Medications	Repeated/Prolonged Antibiotic Use
Fall/jump from 3 feet or more	Fall/jump from less than 3 feet	Emotional Trama

2) **Adulthood:**

Smoker	Inhaler use	Surgery
Vaccination	Sports	Head Trauma
Alcohol Consumption	Workplace Stress	Fall/Jump from a height
Prescription Medications	Extreme Sports	Coffee Drinker
Drug Use/Abuse	Emotional Stress	Traumas: _____

Women only, is there a chance you're pregnant? ❑ Yes ❑ No If so, how many weeks? _____

GOALS:

Which best describes the reason you are consulting our office?

❑ Have a specific concern and require help with only this concern
❑ I want to ensure my health concerns don't become an ongoing problem impacting my future health
❑ I want to be healthier 5 years from now than I am today

I the undersigned agree that I am responsible for payment for all services rendered by Precise Moves Chiropractic. I hereby authorize any insurance rights and benefits (if applicable) directly to Precise Moves Chiropractic for services rendered. I clearly understand and agree that all services rendered me are charged directly to me and I am personally and financially responsible whether or not insurance submits payments.

Patient/Parent: _____ Date: _____