Princeton Chiropractic Wellness Center

Welcome to the Princeton Chiropractic Wellness Center. Please fill in the following completely and clearly. **Date:** _____

CONTACT INFORMATION (please print clearly):

Last name: _____ First name: _____
Address: _____ Phone (Home): _____
City: _____ State: _____ Zip code: _____ (Work): _____
Date of Birth: _____ Age: _____ (Cell): _____
Occupation and Type of work: _____
Family physician: _____ Marital Status: _____
Names and ages of children: _____
How did you find out about our office? _____
E-mail address: _____ May we send you our office newsletter? □ Yes □ No

Health Profile

What are your objectives in consulting our office? _____

If your health could be ideal what would it look like? _____

_____

Who was the last doctor who created a health development plan for you? _____

Did you follow all the doctor's recommendations? □ Yes □ No

How long were you able to stay on the health development plan? _____

What were your results? _____

What other wellness professionals are currently a part of you health care team?
□ Massage Therapist □ Acupuncturist □ Naturopath □ Homeopath □ Other

How many medical doctor's office visits did you and your family have last year?
□ None □ Less than 5 □ More than 5 □ More than 10

Have you had previous chiropractic care? □ Yes □ No This year? □ Yes □ No
List previous surgeries and dates: _____

Medications: □ Pain Meds □ Birth control □ Heart Meds □ Cholesterol Meds □ Other

Lifestyle Information

Do you exercise? □ Yes □ No If yes, how much and how often? _____

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

Do you consume alcohol? □ Yes □ No If yes, how much and how often? _____

Do you consume caffeine? □ Yes □ No If yes, how much and how often? _____

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

How many hours of sleep do you typically get per night? _____

Health History

Please check all of the following health concerns that you have experienced, even if you do not think that your answers relate to your present health concern.

Allergies	□ Yes □ No	Heart Condition	□ Yes □ No
Anxiety	□ Yes □ No	Immune System Disorder	□ Yes □ No
Arthritis	□ Yes □ No	Infertility	□ Yes □ No
Asthma	□ Yes □ No	Kidney Disease	□ Yes □ No
Back Pain	□ Yes □ No	Menstrual Cramps	□ Yes □ No
Bladder Problems	□ Yes □ No	Mood Swings	□ Yes □ No
Cancer	□ Yes □ No	Neck Pain	□ Yes □ No
Circulatory/Vascular Disorder	□ Yes □ No	Numbness/Tingling	□ Yes □ No
Depression	□ Yes □ No	Osteoporosis	□ Yes □ No
Diarrhea	□ Yes □ No	Sinus Trouble	□ Yes □ No
Digestive Problems	□ Yes □ No	Skin Conditions	□ Yes □ No
Dizziness	□ Yes □ No	Urinary Difficulty	□ Yes □ No
Headaches	□ Yes □ No	Vertigo	□ Yes □ No
Heartburn/Reflux	□ Yes □ No	Other:_____	□ Yes □ No

Stress History

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

1. Childhood

Repeated/Prolonged antibiotic use	□ Yes □ No	Inhaler use	□ Yes □ No
Car Accident	□ Yes □ No	Prescription Medications	□ Yes □ No
Childhood illness	□ Yes □ No	Surgery	□ Yes □ No
Fall/Jump from a height<3 feet	□ Yes □ No	Vaccination	□ Yes □ No
Fall/Jump from a height>3 feet	□ Yes □ No	Youth Sports	□ Yes □ No
Head Trauma	□ Yes □ No	Other Traumas (physical or emotional):	

2. Adulthood

Alcohol Consumption	□ Yes □ No	Inhaler Use	□ Yes □ No
Repeated/Prolonged antibiotic use	□ Yes □ No	Prescription Medications	□ Yes □ No
Car accident	□ Yes □ No	Smoker	□ Yes □ No
Coffee Drinker	□ Yes □ No	Surgery	□ Yes □ No
Drug use/abuse	□ Yes □ No	Contact sports	□ Yes □ No
Fall/jump form a height	□ Yes □ No	Extreme sports	□ Yes □ No
Head trauma	□ Yes □ No	Workplace stress	□ Yes □ No
Home environment stress	□ Yes □ No	Other traumas (physical or emotional):	

(New practice member health objectives)

----------Do not write below this line. For Doctor's use only----------

□ Temporary symptom relief only.
□ Prevention of recurrence of symptoms.
□ Maintenance of good health.
□ Health development.