

**Cree Guardino, BS, DC, DICCP  
Doctor of Chiropractic**

Full Name: \_\_\_\_\_ Email Address: \_\_\_\_\_ Date: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male Female  
 Spouse/Significant Other: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Children's Names and Ages: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Emergency Name and Number: \_\_\_\_\_  
 How did you hear about the doctor? If someone referred you, what is their name? \_\_\_\_\_  
 Is there a specific reason for consulting our office at this time? \_\_\_\_\_

**YOUR HEALTH PROFILE**

As a full spectrum chiropractic office we focus on your ability to be healthy. Our goals are first to address the issues that brought you to the office, and second, to offer you the opportunity for improved health potential and wellness-services in the future. On a daily basis, we experience physical, chemical and emotional stress that can accumulate and result in a 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.

**YOUR CHILDHOOD YEARS**

Research shows that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	<b>YES</b>	<b>NO</b>	<b>UNSURE</b>	<b>COMMENTS</b>
Did you have any childhood illness?				_____
Did you have any serious falls as a child?				_____
Did you play youth sports?				_____
Did you take/use any drugs?				_____
Did you have any surgeries?				_____
Have you fallen/jumped from a height over three feet (i.e. crib, bunk bed, trees)?				_____
Were you involved in any car accidents as a child?				_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?				_____
Did you suffer any other traumas (physical or emotional)?				_____
Were you vaccinated?				_____
As a child, were you under regular chiropractic care?				_____

## YOUR ADULT YEARS

	YES	NO	UNSURE	COMMENTS
Do you drink water daily?				How much: _____
Do you drink caffeine?				How much: _____
Do/did you smoke?				How much: _____
Do/did you drink alcohol?				How much: _____
Any surgeries/hospitalizations?				_____
Do you take any supplements/vitamins?				What kind/which brand: _____
Do/did you play any adult sports?				_____
On a scale of 0 – 10 describe your stress level (0 = none / 10 = extreme):				Occupational _____ Personal _____
On a scale of Poor-Good-Excellent describe your:				Diet: _____ Exercise: _____ Sleep: _____ General Health: _____
Have you ever:				Bought bottled water: YES NO Belonged to a health club: YES NO

## Chief Complaint If Not A Wellness Visit

If you have no specific symptoms or complaints, and you are here for Chiropractic Wellness Services please (X) here \_\_\_\_\_ and skip to the Family Profile section of this form. All others please briefly describe your chief area of complaint:

Include the effect it has had on your life:

Yes, it interferes with...	Work	Sleep	Walking	Sitting	Hobbies	Leisure
If you are experiencing pain, is it...	Sharp	Dull	Comes and goes		Travels	Constant
Since the problem started, it is...	About the Same		Getting Better		Getting Worse	
What makes it worse?	_____					

Other Doctors seen for this problem (please list):

Chiropractors \_\_\_\_\_

Medical Doctors/Other \_\_\_\_\_

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

Headache	Pins and Needles in Leg	Fainting	Neck Pain
Fatigue	Loss of Smell	Back Pain	Loss of Balance
Dizziness	Fever	Ringin g in Ears	Nervousness
Numbness in Fingers	Numbness in Toes	Loss of Taste	Stomach Upset
Pins and Needles in Arms	Depression	Irritability	Tension
Sleeping Problems	Neck Stiffness	Cold Hands	Cold Feet
Diarrhea	Constipation	Buzzing in Ear	Hot Flashes
Cold Sweats	Ulcers	Problem Urinating	Heartburn
Menstrual Irritability	Menstrual Pain	Mood Swing	Eyes Sensitive to Light

List any medications you are currently taking: \_\_\_\_\_

## FAMILY HEALTH PROFILE

We are not only interested in your health and well-being, but also about your family and loved ones. Please mention below any health conditions or concerns you may have about your...

Children \_\_\_\_\_

Spouse/Partner/Significant Other \_\_\_\_\_

Parents \_\_\_\_\_

Siblings \_\_\_\_\_

Others \_\_\_\_\_

***The statements made on this form are accurate to the best of my knowledge.***

Signature \_\_\_\_\_

Date \_\_\_\_\_