Dr.Cree Guardino, BS, BA, DC, DICCP

Full Name: Date:

Social Security Number: DOB: Age: Male / Female *(please circle)*

Home Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Email Address:

Spouse/Significant Other: DOB: Social Security Number:

Children's Names and Ages:

Employer: Employer Address:

City: State: Zip:

Emergency Name and Phone Number:

How did you hear about us *(please specify name of referral)*?

Is there a specific reason for consulting our office at this time?

Your Health Profile

As a full spectrum 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 serious loss of health potential. Most times the effects and 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.

	Yes	No	Unsure	Comments
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?	☐	☐	☐	

	Yes	No	Unsure	Comments
Did you have any surgeries?	☐	☐	☐	
Have you fallen/jumped from a height over 3 ft?	☐	☐	☐	
Were you involved in any car accidents as a child?	☐	☐	☐	
Was there any prolonged use of medicine (i.e. inhaler)?	☐	☐	☐	
Did you suffer any other traumas?	☐	☐	☐	
Were you vaccinated?	☐	☐	☐	
As a child, were you under regular chiropractic care?	☐	☐	☐	

Your Adult Years

	Yes	No	Unsure	
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/brand:
Do/did you play any adult sports?	☐	☐	☐	

On a scale 0-10 describe your stress (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 Y / N *(please circle)* Belonged to a health club Y / N *(please circle)*

Addressing The Issues That Brought You To The Office

If you have no specific symptoms or complaints, and you are here for Chiropractic and/or Therapeutic Massage please mark (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)*:

____

Does symptom(s) interfere with: ☐ Work ☐ Sleep ☐ Walking ☐ Sitting ☐ Hobbies ☐ Leisure

If you are experiencing pain, it is: ☐ Sharp ☐ Dull ☐ Comes and goes ☐ Travels ☐ Constant

Since the problem started, it is: ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse? ____

Please indicate who else you have seen for this problem:

Chiropractors: ____

Medical Doctors/Others: ____

Please indicate all symptoms you have had, even if they do not seem related to your current problem:

☐ Headache	☐ Pins/Needles in Legs	☐ Fainting	☐ Neck Pain
☐ Fatigue	☐ Loss of Smell	☐ Back Pain	☐ Loss of Balance
☐ Dizziness	☐ Fever	☐ Ringing in Ears	☐ Nervousness
☐ Numbness in Fingers	☐ Numbness in Toes	☐ Loss of Taste	☐ Stomach Upset
☐ Pins/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

Please indicate the conditions below that have affected your health either recently or in the past.

☐ Arthritis	☐ Constipation	☐ Diverticulitis	☐ Pregnancy
☐ Diabetes	☐ Diarrhea	☐ Headaches	☐ Scoliosis
☐ Blood Clots	☐ Skin Conditions	☐ Heart Conditions	☐ Seizures
☐ Broken/Dislocated Bones	☐ Stroke	☐ Back Problems	☐ Whiplash
☐ Bruise Easily	☐ Surgery	☐ High Blood Pressure	☐ Hepatitis (A, B, C, other)
☐ Cancer	☐ TMJ Disorder	☐ Insomnia	☐ Chemical Dependency
☐ Chronic Pain	☐ Depression	☐ Muscle Strain/Sprain	☐ Auto-Immune Condition

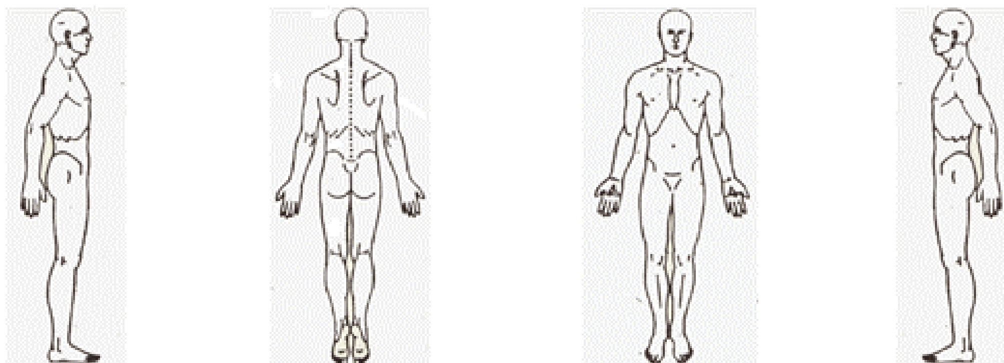
If any of the above needs to be detailed or if there is anything else you would like to share, please do so here:

____

____

Please list any medications you are currently taking: ______________________________

Please indicate with an (x) the areas in which you are feeling discomfort:



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 you may have about you:

Children: ______________________________

Spouse/Significant Other: ______________________________

Parents: ______________________________

Siblings: ______________________________

Others: ______________________________

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

____

Signature *Date*

____

Once again, we would like to welcome you to our office.

If you have any questions regarding your health and wellness care please don't hesitate to ask.