

**Alternative Chiropractic & Wellness Center/Dr. Philip Seng, DC**  
**New Client Health Profile Form**

**Please tell us about yourself:**

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Out-of-state address, if applicable: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Sex (M/F): \_\_\_\_\_ Martial (S, M, D, W, Sep): \_\_\_\_\_ No. of Children at Home: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

In Case of Emergency, Contact: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone(s): \_\_\_\_\_

Name of Current Medical Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Who may we thank for referring you to our facility? \_\_\_\_\_

If through advertising, please describe: \_\_\_\_\_

Is your current condition the result of a recent auto accident?    Y    N

*If yes, please inform the front desk staff immediately to obtain the additional necessary paperwork.*

If applicable, will you be filing claims with a health insurance carrier?    Y    N

Carrier: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Your Health Profile – Why this form is important**

At Alternative Chiropractic & Wellness Center, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office, and second, to offer you the opportunity of improved health, wellness and quality of life in the future. On a daily basis we all experience physical, biochemical, and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of specific stresses, past and present, that you face and allow us to better assess the challenges to your health potential.

**If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "General History" (Section 2, page 4).**

Please describe below, in the following sections, your primary, secondary and additional reasons for seeking care in our office.

**Primary Concern (list one only):**

When did you first experience the problem?

How did this problem first begin?

How often do you experience this problem? ( ) 1-2x/month ( ) 3-4x/month ( ) 2-5x/month ( ) daily ( ) constantly

Please grade the intensity of this problem with 10 being the worst:

At it's best                    1      2      3      4      5      6      7      8      9      10

At it's worst                    1      2      3      4      5      6      7      8      9      10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)

Please describe the location of the concern:

Does this problem cause pain to travel to any other area of your body?    Y      N      If yes, where?

Is this problem getting: ( ) worse      ( ) better      ( ) staying the same

What seems to aggravate this problem? (movements, postures or positions, time of day, allergies, chemical exposures, emotional stresses, etc.)

What seems to help relieve this problem, if anything (stretches, exercises, medication, lifestyle changes, etc.)?

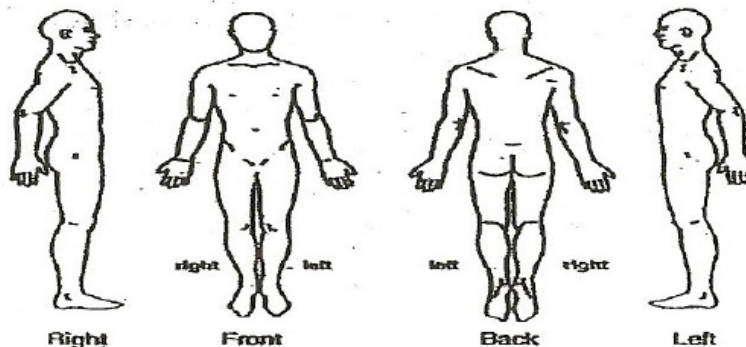
Have you seen any other doctors or professionals for this problem?    Y      N      If yes, who?

What treatment was given?

How effective was the care?

If you are experiencing pain, please indicate the location on the diagram below, using the symbols:

- Stabbing**  
+++++++
- Aching**  
/////
- Burning**  
=====
- Numbness**  
OOOOOOOO
- Pins & Needles**  
^ ^ ^ ^ ^ ^ ^ ^ ^ ^



**Second Concern (list one only):**

When did you first experience the problem?

How did this problem first begin?

How often do you experience this problem? ( ) 1-2x/month ( ) 3-4x/month ( ) 2-5x/month ( ) daily ( ) constantly

Please grade the intensity of this problem with 10 being the worst:

At it's best	1	2	3	4	5	6	7	8	9	10
At it's worst	1	2	3	4	5	6	7	8	9	10

How would you describe the symptoms (i.e. burning, stabbing, aching, sharp, etc.)

Please describe the location of the concern:

Does this problem cause pain to travel to any other area of your body? Y N If yes, where?

Is this problem getting: ( ) worse ( ) better ( ) staying the same

What seems to aggravate this problem? (movements, postures or positions, time of day, allergies, chemical exposures, emotional stresses, etc.)

What seems to help relieve this problem, if anything (stretches, exercises, medication, lifestyle changes, etc.)?

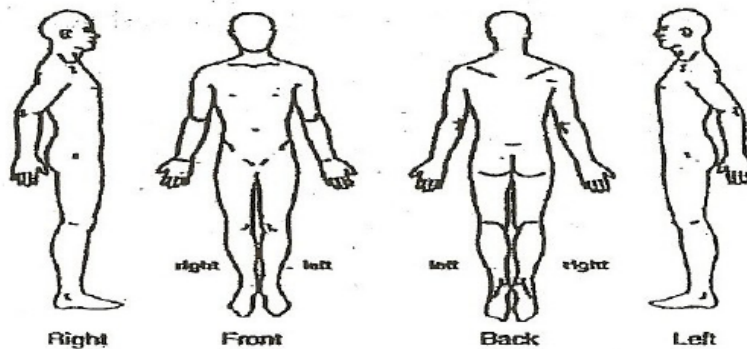
Have you seen any other doctors or professionals for this problem? Y N If yes, who?

What treatment was given?

How effective was the care?

If you are experiencing pain, please indicate the location on the diagram below, using the symbols:

- Stabbing**  
+++++++
- Aching**  
/////
- Burning**  
=====
- Numbness**  
OOOOOOOO
- Pins & Needles**  
A A A A A A A A A A



*If you have any further complaints, please ask the front desk for additional forms.*

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## **SECTION 2**

### **GENERAL HEALTH AWARENESS**

Please rate your overall health status:

Poor    1        2        3        4        5        6        7        8        9        10      Excellent

What are your health objectives? \_\_\_\_\_  
\_\_\_\_\_

Name/address/phone of the last doctor who put you on a health development program: \_\_\_\_\_  
\_\_\_\_\_

Were you able to stay on the program?    Y        N        How long? \_\_\_\_\_

What were your results? \_\_\_\_\_  
\_\_\_\_\_

Are you healthier today than you were 5 years ago?    Y        N        Not Sure

If yes, what did you do to improve your health? If no, why do you think your health has declined?  
\_\_\_\_\_  
\_\_\_\_\_

Do you believe you will be healthier 5 years from now than you are today?    Y        N        Not Sure

If yes, what are you doing to improve your health? If no, what could you do to improve your health rather than have it continue to decline? \_\_\_\_\_  
\_\_\_\_\_

Have you had previous chiropractic care?    Y        N

If yes, what was the doctor's name? \_\_\_\_\_

How long did your care last, at that time? \_\_\_\_\_

Are you aware that:

Doctors of Chiropractic work with the nervous system?	Y	N
The nervous system controls all the bodily functions and systems?	Y	N
Chiropractic is the largest natural healing profession in the world?	Y	N
If chiropractic care starts at birth, you can achieve a higher level of health throughout life?	Y	N

What other wellness professionals are currently parts of your health care team?

( ) Massage therapist    ( ) Acupuncturists    ( ) 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

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### SECTION 3

#### LIFESTYLE/SOCIAL HISTORY

On a scale of 1-10, please rate your stress level (10 is the maximum level):

Occupational \_\_\_\_\_

Personal \_\_\_\_\_

Do you smoke or chew tobacco?                    Y     N     If yes, how much? \_\_\_\_\_

Do you drink alcohol?                            Y     N     If yes, how much? \_\_\_\_\_

Do you drink coffee/tea?                        Y     N     If yes, how much? \_\_\_\_\_

Do you drink soda?                                Y     N     If yes, how much? \_\_\_\_\_

Do you drink water?                              Y     N     If yes, how much? \_\_\_\_\_

Do you use recreational drugs?                Y     N     If yes, how much? \_\_\_\_\_

Recreational activities: \_\_\_\_\_

How regularly do you exercise?                ( ) daily            ( ) \_\_\_x/week            ( ) occasionally            ( ) never

What kinds of exercise do you do?            ( ) aerobic            ( ) weight lifting            ( ) yoga            ( ) stretching            ( ) calisthenics

Have you ever been given advice, from a physician, not to exercise?            Y     N     \_\_\_\_\_

Do you have negative feelings toward exercise?    Y     N     \_\_\_\_\_

Do you have problems with sleeping?    Y     N     \_\_\_\_\_

How many hours of sleep do you get, on average, per night? \_\_\_\_\_

How many times per day do you eat? \_\_\_\_\_

How would you rate your diet/food choices:            *0 is poor, i.e. fast foods*    *10 is excellent, i.e. organic*

Poor    1        2        3        4        5        6        7        8        9        10        Excellent

Do you crave certain foods and if yes, which ones? \_\_\_\_\_

Are you on any diet or eating plan currently? \_\_\_\_\_

Do you feel you need to gain or lose weight? \_\_\_\_\_

Do you have any food allergies? \_\_\_\_\_

Number of bowel movements per day? \_\_\_\_\_

List the nutritional supplements that you use regularly:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you don't use supplements regularly, do you have any negative feelings towards them?    Y     N

#### **WOMEN ONLY:**

Pregnancies and Outcome:            ( ) none

Number of pregnancies: \_\_\_\_\_    Number of children: \_\_\_\_\_

Age and sex of each child (i.e. 10-F, 15-M): \_\_\_\_\_

When was your last period? \_\_\_\_\_

Is your menstruation regular? \_\_\_\_\_

Are you pregnant now?                    Y     N     Not sure

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**SECTION 4****MEDICAL HISTORY**

Please list the cause of death and age of any immediate family members (parents, siblings, and children):

Relationship	Cause of Death	Age at Death
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please check any of the following illnesses you have had:

- |                       |                        |                       |
|-----------------------|------------------------|-----------------------|
| _____ Pneumonia       | _____ Mumps            | _____ Influenza       |
| _____ Rheumatic Fever | _____ Small Pox        | _____ Pleurisy        |
| _____ Polio           | _____ Chicken Pox      | _____ Arthritis       |
| _____ Tuberculosis    | _____ Diabetes         | _____ Epilepsy        |
| _____ Whooping Cough  | _____ Cancer           | _____ Mental Disorder |
| _____ Anemia          | _____ Heart Disease    | _____ Lumbago         |
| _____ Measles         | _____ Thyroid Disorder | _____ Eczema          |

**Surgeries:**

Date	Type	Reasons for surgery
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Previous injuries or trauma:**

Date	Type
_____	_____
_____	_____
_____	_____

**Medications (including over-the-counter medications):**

Medication	Reason for taking
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Allergies (food, chemical or inhalant):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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## SECTION 5

### STRESS HISTORY

Please indicate (by circling) whether you have experienced increased stress in any of the following areas. Your answers will enable us to determine which factors have contributed to your present health condition/concerns.

#### Childhood

##### Structural Stress

Falls  
Jumps over 3 feet in height  
Head trauma  
Birth trauma  
Youth sport injuries  
Extreme sports  
Car accidents

##### Chemical Stress

Repeated/prolonged antibiotic use  
Inhaler use  
Prescription medication  
Vaccinations  
Smoker  
Illegal drug use  
Alcohol consumption  
Caffeine consumption

##### Emotional Stress

Parental divorce/separation  
Abandonment  
Feeling of not fitting in  
Depression  
Anxiety  
Fear

#### Adulthood

##### Structural Stress

Car accidents  
Fall/jumps  
Head trauma  
Sports injuries  
Contact injuries  
Extreme sports

##### Chemical Stress

Alcohol consumption  
Repeated/prolonged antibiotic use  
Coffee drinking (> 1 cup)  
Illegal drug use/abuse  
Prescription drug use/abuse  
Inhaler use  
Smoker  
Exposure to chemicals

##### Emotional Stress

Depression  
Anxiety  
Fear  
Family stress  
Work stress  
Money worries

Please check any of the following you have had in the last six months:

#### Musculo-skeletal

Low back pain  
 Pain between shoulders  
 Neck Pain  
 Arm pain  
 Joint pain/stiffness  
 Walking problems  
 Hard chewing/clicking jaw  
 General stiffness  
 Headaches

Excessive thirst  
 Fatigue  
 Fever  
 Insomnia

Cold hands/feet  
 Excessive phlegm  
 Sinus problems  
 Chronic coughing

#### Nervous System

Nervous  
 Numbness  
 Paralysis  
 Forgetfulness  
 Confusion  
 Depression  
 Fainting  
 Convulsions  
 Cold/tingling extremities  
 Stress  
 Tremors  
 Muscle weakness  
 Loss of balance  
 Memory loss  
 Irritability

#### Gastro-Intestinal

Poor/Excessive appetite  
 Excessive thirst  
 Frequent nausea  
 Vomiting  
 Diarrhea  
 Constipation  
 Hemorrhoids  
 Liver problems  
 Gall bladder problems  
 Weight gain/loss  
 Abdominal cramps  
 Gas/bloating after meals  
 Heartburn  
 Black/bloody stools  
 Colitis  
 Ulcers

#### Eyes, Ears, Nose and Throat

Enlarged glands  
 Vision problems  
 Dental problems  
 Sore throat  
 Ear aches  
 Loss of hearing  
 Tinnitus  
 Sinus problems  
 Nose bleeds

#### Male/Female

Menstrual irregularity  
 Menstrual cramps  
 Vaginal pain/infection  
 Breast pain/lumps  
 Prostate/sexual dysfunction  
 Frequent urination  
 Can't control urination  
 Other problems:

#### General

Anemia  
 Cancer  
 Diabetes  
 Epilepsy

#### Cardiovascular/Respiratory

Chest pain  
 Blood clots  
 Shortness of breath  
 Blood pressure problems  
 Irregular heartbeat  
 Heart problems  
 Lung problems/congestion  
 Varicose veins  
 Ankle swelling  
 Stroke

#### Immune System

Fibromyalgia  
 Arthritis  
 Gout  
 Frequent colds/flu  
 Allergies  
 Rashes

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**SECTION 6**

**SIGNATURES/AUTHORIZATIONS**

**Which best describes your reason for consulting our office?**

\_\_\_\_\_ I have a specific concern and require help with this concern.

\_\_\_\_\_ I want to ensure that my health concerns do not become ongoing problems that will impact my future health.

\_\_\_\_\_ I want to be healthier, five years from now, than I am today.

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**X** To the best of my knowledge, I have been truthful and have included everything concerning my past and present health conditions. I fully consent to a professional and complete chiropractic examination at a level deemed necessary by the doctor.

\_\_\_\_\_  
*Patient or Legal Guardian*

\_\_\_\_\_  
*Date*

**X** I hereby give complete authorization to have any x-rays take of me that are necessary for my treatment plan.

\_\_\_\_\_  
*Patient or Legal Guardian*

\_\_\_\_\_  
*Date*

**X** To the best of my knowledge, I am NOT pregnant and give complete authorization to be x-rayed as necessary for my treatment plan.

Date of last menstrual period: \_\_\_\_\_

\_\_\_\_\_  
*Patient or Legal Guardian*

\_\_\_\_\_  
*Date*