2055 Third Ave., Suite B, San Diego, CA 92101 ● (619) 239-0053 ● www.WarrenFamilyWellness.com

NAME: ______________________________ DATE: ______________

ADDRESS: ______________________________

CITY / STATE / ZIP: ______________________________

HOME PHONE #: ____________ WORK PHONE #: ____________ CELL #: ____________

E-MAIL ADDRESS: ______________________________

BIRTH DATE: ____________ AGE: _____ ☐ Male ☐Female MARITAL STATUS: ☐ Single ☐ Married

OCCUPATION: ____________________ EMPLOYER'S NAME: ____________________

OF CHILDREN: ________ NAMES & AGES: ______________________________

____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? ____________________

YOUR HEALTH PROFILE

► What brings you into our office today*? ______________________________

____

____

Please briefly describe the impact it has had on your life:
When & How did this start? Have you experienced this before? Are symptoms constant or intermittent?

____

____

____

*If you are here for chiropractic wellness services only, please skip this part and go to "General History" on the next page.

► Since the problem started, is it: ☐ the same ☐ getting better ☐ getting worse?

What makes the problem worse? ______________________________

What, if anything, makes the problem feel better?______________________________

► Does this interfere with your: ☐ Work ☐ Sleep ☐ Sports/Recreation ☐ Leisure ☐ Other?

____

► Have you seen other doctors/practitioners for this condition? ☐ Chiropractor ☐ MD ☐ Other?

Name(s):______________________________Date(s):______________

What was the diagnosis?______________________________

GENERAL HISTORY

► List any medications you are taking and why (prescription and non-prescription):

____

____

► Have you had any surgeries and/or hospitalizations? ☐ Yes ☐ No

If yes, briefly explain: ____

____

► Have you ever had any work related injuries? ☐ Yes ☐ No

If yes, briefly explain: ____

____

► Have you ever had any slips, falls or auto accidents? ☐ Yes ☐ No

If yes, briefly explain: ____

____

► On a scale of 1-10 (1 = none, 10 = extreme), describe your current levels of lifestyle stress:

Scale = ____ Occupational stress: ____

Scale = ____ Personal stress: ____

► On a scale of 1-10 (1 = poor, 10 = excellent), describe your lifestyle habits in the following areas:

____ Mindset ____ Exercise ____ Eating ____ Sleep/Relaxation ____ Enjoyment ____ Overall Healthy Lifestyle

Please check (☐) all symptoms you are currently experiencing, or have had significant difficulty with in the past:

☐ Headaches	☐ Asthma	☐ Tired after eating	☐ Lower back pain / stiffness
☐ Neck pain / stiffness	☐ Breathing problems	☐ Indigestion	☐ Sciatica
☐ Spacey / Brain Fog	☐ Fatigue / Low Energy	☐ Heartburn / Ulcers	☐ Pins & needles in legs
☐ Memory Trouble	☐ Sleeping problems	☐ Gas / Bloating	☐ Cold Hands / Feet
☐ Pins and needles in arms	☐ Overwhelmed by stress	☐ Diarrhea	☐ Diabetes
☐ Numbness in fingers	☐ Depression	☐ Constipation	☐ Osteoporosis
☐ Buzzing / Ringing in ears	☐ Irritability	☐ Urinary Problem	☐ Cancer
☐ Sinus Problems / Snoring	☐ Anxiety	☐ Menstrual Pain	☐ Heart Disease
☐ Allergies	☐ Dysmenorrhea (PMS)	☐ Menstrual Irregularity	☐ Autoimmune Disorder
☐ Frequent Colds / Flu's	☐ Hot Flashes	☐ Infertility	☐ Prolonged use of medication

☐ Any other symptoms not listed: ____

____

____

YOUR GOALS

► If you could have it *any* way you wanted it, what would your health and wellness be like? ______________________________

____

► What is one thing you could **start** doing that would allow you to have it this way? ______________________________

____

► What is one thing you should **stop** doing that would allow you to have it this way? ______________________________

____

► What are your Health and Wellness Goals for yourself **right now** that you would like my help with?

____

____

► With regard to what brought you into our office, are you interested in: ☐ temporary relief? or ☐ permanent solutions?

If Lifestyle recommendations are appropriate for you, would you be interested in learning more about:

☐ Proper Exercise routines & techniques? ☐ Proper Nutrition and meal planning? ☐ How to deal with Lifestyle stress?

► Are there any other health concerns or anything else you'd like us to know about you? ☐ Yes ☐ No

If yes, please tell us: ____

____

Thank you for filling out this form.
It is your first step to creating more health, more balance and more happiness for yourself!

I consent to a professional and complete chiropractic examination and to any further examination procedures that the doctor deems necessary. I understand that all fees for services rendered are due at the time of service and cannot be deferred to a later date.

Signature____ Date: ____________________

For Office Use Only:

Objectives:
- ☐ Relief/Correction (**Reclaim**)
- ☐ Stabilization-Strengthening (**Renew**)
- ☐ Maintenance (**Prevention**)
- ☐ Wellness (**Revitalize**)