

General Health Profile

Date: _____

Contact Information:

Name: _____ Home Phone # _____ Cell Phone # _____

Mailing Address: _____ City: _____ Zip: _____

E-Mail Address: _____

Additional Contacts / Emergency Contact:

Name: _____ Relationship: _____ Phone # _____

Whom May We Thank For Your Referral: _____

Would you like Dr. Walk to contact a family member or friend about Chiropractic/Acupuncture/Nutrition/etc...

Name: _____ Phone #: _____ E-Mail: _____

Please tell us about yourself:

Date of Birth: _____ Height: _____ Weight: _____ Gender: M / F

Occupation: _____

Please list the top 3 stressors you may have: (physical, mental, social, chemical, etc...)

Have you ever had Chiropractic Care / Acupuncture / Auriculotherapy: Yes / No

(If yes) When/Where/Why: _____

Please explain your reason for the visit and any hopes or expectations you may have:



Please circle any problems past or present for the body parts listed below & explain: Where/When/How/What

- | | | | |
|-----------|------------|--------------|------------------------|
| 1) Ankle | 6) Foot | 11) Leg | 16) Toes |
| 2) Arm | 7) Forearm | 12) Neck | 17) Wrist |
| 3) Back | 8) Head | 13) Pelvis | 18) Other. List below. |
| 4) Elbow | 9) Hip | 14) Shoulder | _____ |
| 5) Finger | 10) Knee | 15) Thigh | |

Explain: _____

Please circle all symptoms you had or have and explain below: Where/When/How/What etc...

- | | | |
|-----------------|----------------------------|------------------------------|
| 1) Cold hands | 13) Hot flashes | 25) Pins and needles in arms |
| 2) Cold feet | 14) Irritability | 26) Pins and needles in legs |
| 3) Cold Sweats | 15) Lights bother eyes | 27) Ringing in ears |
| 4) Constipation | 16) Loss of balance | 28) Sleeping problems |
| 5) Depression | 17) Loss of smell | 29) Stomach upset |
| 6) Diarrhea | 18) Loss of taste | 30) Stiff Neck |
| 7) Dizziness | 19) Menstrual irregularity | 31) Tension |
| 8) Fainting | 20) Menstrual pain | 32) Ulcers |
| 9) Fatigue | 21) Mood Swings | 33) Urinary problems |
| 10) Fever | 22) Nervousness | 34) Other. List below... |
| 11) Headaches | 23) Numbness in fingers | _____ |
| 12) Heartburn | 24) Numbness in toes | |

Explain: _____

If you take medications, what are you taking them for? (Prescription and non-prescription)

Have you had any surgery: (please include all surgeries)

1. Type _____ Date: _____ Doctor _____

2. Type _____ Date: _____ Doctor _____

3. Type _____ Date: _____ Doctor _____

Accidents / Injuries / Illness: (auto, work related, falls, head injuries, childhood illness, etc...)

1. Type _____ Date: _____ Hospitalized [] Yes [] No

2. Type _____ Date: _____ Hospitalized [] Yes [] No

3. Type _____ Date: _____ Hospitalized [] Yes [] No

Have you ever had X-Rays / MRI / CT taken: [] Yes [] No

(If Yes) Please Explain: _____

Please List Any Allergies Here: _____

Do you wear orthotics or heel lifts? [] Yes [] No _____

Do You Smoke? Yes / No Quantity: _____

Sleeping Questions: Hours of Sleep _____ Position: Side / Belly / Back

Does pain wake you at night: Yes / No Quality of Sleep: Excellent / Good / Fair / Poor

Are or could you be pregnant? Yes / No If yes, how far along are you? _____

Please Briefly Describe Your Exercise: (What, How Long, How Far, etc...) _____

Please list any supplements you consume and why:

Please rank the following (1 thru 8) from most consumed to least consumed on average:

[] Fruits [] Veg. [] Meat [] Water [] Grains [] Dairy [] Sweets [] Caffeine

