Re-Exam Wellness Profile

Last Name:	First Name:	Date:

Please check the type of care desired:

- ○ General Health/Prevention
- ○ Stabilization
- ○ Temporary Relief
- ○ Doctor's Advice
- ○ Other _____

PERSONAL INFORMATION * only fill out starred items if they have changed

First Name:	M.I.	Last Name:

Preferred Name:	*Street Address:

*City:	*State:	*Zip:

*Cell Phone:	*Alternate Phone:	*Email:

*Work Phone:	*Occupation:	*Employer's Name:

Emergency Contact:	Phone:	Relationship:

CURRENT HEALTH CONCERNS

List any health concerns that have been **resolved** since starting chiropractic:

List any health concerns that have **improved** since starting chiropractic:

What are your current health concerns, starting with the most important to you?

1

2

3

4

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Please answer the following questions about your **primary** current health concern from above.

When/how did this concern begin?

What activities **aggravate** your concern?

What activities **alleviate** your convern?

Is the condition worse during certain times of the day? If yes, when?

○ Y ○ N

Does it affect your:

☐ Work ☐ Relationships ☐ Decision Making ☐ Exercise or Play

☐ Mood, Patience ☐ Ability to Relax or Sleep ☐ Day-to-Day Activities ☐ Other _____

Explain any of the above:

On a scale of 1-10 (1 least & 10 most), please circle the severity of your symptoms **today**:

1 2 3 4 5 6 7 8 9 10

Do you have:

☐ Pain ☐ Numbness

☐ Tingling ☐ Aches

Explain:

Is your pain:

○ Sharp ○ Dull ○ Throbbing ○ Constant ○ Intermittent

Explain:

Do you feel:

☐ Swelling ☐ Cramping ☐ Stiffness ☐ Burning

Explain:

Is there anything else about your current condition you feel the doctor should know?

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UPDATED HISTORY Please read carefully & answer in relation to your last exam

Mark all that apply with (R) for Resolved, (I) for Improved & (NC) for New Concern

- ☐ Weight changes
- ☐ Frequent colds/Flu
- ☐ Respiratory problems
- ☐ Sinus problems/Allergies
- ☐ Anemia
- ☐ Skin conditions
- ☐ Neck/Back pain
- ☐ High cholesterol
- ☐ Stroke
- ☐ High blood pressure
- ☐ Anxiety/Depression
- ☐ Bipolar disorder
- ☐ OCD
- ☐ ADD/ADHD
- ☐ SAD
- ☐ Concussion/Head injury
- ☐ Digestive problems
- ☐ Cancer
- ☐ Menstrual problems
- ☐ Reproductive organ disorders
- ☐ Numbness/Tingling
- ☐ Dental/Jaw issues
- ☐ Headaches
- ☐ Diabetes (Type:_____)
- ☐ Urinary tract infections
- ☐ Arthritis (Type? _____)
- ☐ Cold hands/Feet
- ☐ Stiffness/Flexibility
- ☐ Concentration
- ☐ Bowel/Bladder changes
- ☐ Dizziness/Vertigo
- ☐ Ear/Hearing Issues
- ☐ Eye/Vision
- ☐ Thyroid disorder
- ☐ Other: _____

Explain any boxes checked above:

Mark all that currently apply or any changes since your last exam

- ☐ Tobacco
- ☐ Alcohol
- ☐ Recreational drugs
- ☐ Vaccinations
- ☐ Food allergies / sensitivities
- ☐ sugeries / organs removed
- ☐ Dislocations / fractures
- ☐ Falls / injuries
- ☐ Accidents
- ☐ Other _____

Explain:

LIFESTYLE CHANGES

Have any of the following changed since your last exam? (If yes, please explain)

Diet: _____

Exercise: _____

Sleep: _____

Hydration: _____

Mental/Emotional stress: _____

Physical/Emotional stress: _____

Other: _____

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MEDICATIONS & SUPPLEMENTS

Have you **stopped** any medications or supplements since your last exam?

List & reason stopped:

Have you **started** any medications or supplements since your last exam?

List & reason started:

List all medications & suppliments you are currently taking & why:

FOR FEMALES ONLY

Have you had any miscarriages since your last exam?

Y N

Please explain if you wish to share:

RECENT BIRTH (only if you have given birth since your last exam)

Please check the following for your most recent birth:

- Third Trimester Presentation: Vertex, Breech, Transverse, Face/Brow, Posterior
- Type of Birth: Vaginal, Forceps, Vacuum, Cesarean (ER or planned?)
- Interventions: Medication, Epidural, Ruptured Membranes, Other

Delivery location & date:

OB/Midwife name:

PREGNANCY & BIRTH STORY

POSTPARTUM

Since giving birth have you experienced any of the following:

- ☐ Depression/Sadness
- ☐ Pelivic/Pubic pain
- ☐ Hip/Low back pain
- ☐ Unusual bleeding
- ☐ Weakness/Fainting
- ☐ Breast feeding problems
- ☐ Difficulty using the bathroom
- ☐ Diastis recti (only answer if you are 3+ months postpartum)
- ☐ Other _____

Explain any boxes checked above:

Is there anything else which may help us to understand you, your history or your needs that have not been discussed yet? Please explain:

Patient Signature

Date