STEWART CHIROPRACTIC CENTER HEALTH PROFILE

Name_____Today's Date____/____/____Age_____ Male/Female

Address_____City_____State_____Zip_____

Home Phone #: _____ Cell #_____ Date of Birth_____/_____/_____

Email _____ Preference? (circle) TEXT → Carrier: _____ or EMAIL

Occupation_____ Employer's Name _____

Single / Engaged / Married / Divorced / Widowed Spouse's Name (or Parent if a minor) _____

# of Children_____ Names, Ages & Gender_____

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

HOW ARE THESE CONCERNS AFFECTING YOUR HOBBIES AND/OR DAILY LIVING? _____

_____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS? YES / NO

CHIROPRACTOR? _____ MEDICAL DOCTOR?_____OTHER_____

WHO AND WHEN?_____

CIRCLE ALL CURRENT PROBLEMS YOU HAVE

DIZZINESS	*THROAT ISSUES*	*KIDNEY PROBLEMS*	*LIVER DISEASE*	*NERVOUSNESS*
HEADACHES	*THYROID PROBLEMS*	*MID BACK PAIN*	*SHOULDER PAIN*	*EPILEPSY*
VERTIGO	*ASTHMA*	*IRRITABLE BOWEL*	*CHRONIC FATIGUE*	*DISC PROBLEM*
EAR INFECTIONS	*ULCERS*	*SCIATICA*	*LUPUS*	*INFERTILITY*
NAUSEA	*NUMBNESS IN ARMS*	*NUMBNESS IN LEGS*	*FIBROMYALGIA*	*GASTRIC REFULX*
TMJ	*NUMBNESS IN HANDS*	*NUMBNESS IN FEET*	*CHEST PAIN*	
NECK PAIN	*MENSTRUAL DISORDER*	*LOW BACK PAIN*	*ARM PAIN*	*OTHER_____*
MIGRAINES	*HEART DISORDERS*	*HIP PAIN*	*ADD/ADHD*	_____
ANXIETY	*STOMACH DISORDERS*	*LEG PAINS*	_____	_____
CHRONIC SINUS	*BLADDER PROBLEMS*	*KNEE PAIN*	_____	_____

CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

LIST ALL SURGERIES AND YEARS (INCLUDING *SPINAL SURGERIES*) _____

_____

LIST ALL Over the Counter & PRESCRIPTION *MEDICATIONS* YOU ARE ON: _____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT_____

HAVE YOU HAD CHIROPRACTIC CARE BEFORE? NO / YES → DR. & DATE:_____

HAVE YOU EVER BEEN KNOCKED UNCONCIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE_____

OTHER TRAUMA:_____

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

PRACTICE MEMBER NAME WHO IS A MINOR/CHILD _____

NAME OF PERSON FILLING OUT PROFILE AND RELATIONSHIP _____

I AUTHORIZE DR. SAMUEL STEWART AND/OR DR. CLARE STEWART AND ANY AND ALL STEWART CHIROPRACTIC CENTER STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, RENDER CHIROPRACTIC CARE AND PERFORM CHIROPRACTIC ADJUSTMENTS TO MY MINOR/CHILD.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR/CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE CARE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY STEWART CHIROPRACTIC CENTER.

_____ _____

DATE GUARDIAN SIGNATURE

_____ _____

WITNESS SIGNATURE GUARDIAN'S RELATIONSHIP TO MINOR / CHILD