Jones Chiropractic Health Profile

Name: _____ Date:___/___/___

Age ____ Male____ Female____ Date of Birth ___/___/___

Address: _____City: _____ State____ Zip_____

Email: _____ Phone: Home _____ Cell _____

May we include you in our weekly text4health text messages: Yes No (you can stop anytime)

Occupation: _____ Employer: _____

Single / Married / Divorced / Widowed Spouse's name: _____

Number of Children: ___ Names, Ages & Gender _____

_____

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Severity on scale of 1-10	When did episode begin?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent

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

CIRCLE ANY CONDITION YOU HAVE NOW/HAVE HAD:

STROKE CANCER HEART DISEASE SEIZURES SPINAL BONE FRACURE SCOLIOSIS DIABETES

LIST ALL SURGICAL OPERATIONS AND YEARS: _____

_____

LIST ALL OER THE COUNTER & PRESCRIPTION MEDICATIONS YOU ARE ON:

_____ _____ _____

_____ _____ _____

WHEN WAS YOUR LAST AUTO ACCIDENT? _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO

IF YOU HAVE, WHO DID YOU SEE AND WHEN? _____

HAVE YOU EVER BEEN KNOCKED UNCONCIOUS? YES / NO

FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE _____

OTHER TRAUMA: _____

WRITTEN CONSENT FOR A MINOR CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR CHILD _____

I AUTHORIZE DR. ANTHONY JONES TO PERFORM DIAGNOSTIC PROCEDURES, 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 JONES CHIROPRACTIC.

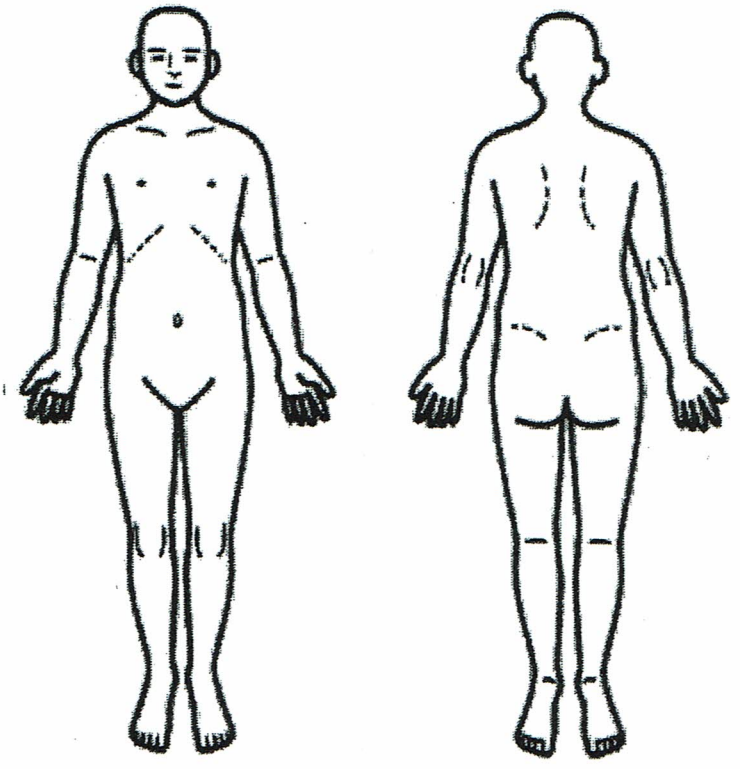
_____ _____

DATE GUARDIAN SIGNATURE

_____ _____

WITNESS SIGNATURE GUARDIAN'S RELATIONSHIP TO MINOR CHILD

12. Please indicate where you are experiencing pain or discomfort.



Acknowledgement & Consent:

Patient Name _____

Signature _____

Date ____/____/____

Family Health History

This form is to assist the Doctors by providing past health information for their review

Condition	Spouse	Son	Daughter	Mother	Father
Arm pain					
Arthritis					
Asthma					
Add/Adhd					
Allergies					
Back Trouble					
Cancer					
Carpal Tunnel					
Deceased					
Diabetes					
Digestive Problems					
Disc Problems					
Fibromyalgia					
Headaches					
High Blood Pressure					
Hip Pain					
Leg Pain					
Migranes					
Neck Pain					
Scoliosis					
Shoulder Pain					
Sinus Trouble					

blueprint nutrition

WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started

Please check any that apply to you:

Sub-Clinical Symptoms Including:

- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:

- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:

- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:

- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:

- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:

- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:

- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:

- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:

- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL _____