

WINER CHIROPRACTIC CENTER

PLEASE PRINT

Full Name: _____ Email Address: _____ Date: _____
 Social Security Number: _____ Date of Birth: _____ Age: _____ Male Female
 Name of Spouse/Significant Other if applicable: _____ # of Children & Ages: _____
 Home Address: _____ City: _____ State: _____ Zip: _____
 Home Phone #: _____ Work Phone #: _____ Cell or Mobile Phone #: _____
 Employer: _____ Employer Address: _____
 City: _____ State: _____ Zip: _____ Emergency Name and Number: _____
 How did you hear about Winer Chiropractic Center? If someone referred you, what is their Name? _____
 Is there a specific reason for consulting our office at this time? _____

YOUR HEALTH PROFILE

As a full spectrum Chiropractic Office we focus on your ability to be healthy. Our goals are first to address the issues that brought you to the office, and second, to offer you the opportunity for improved health potential and wellness-services in the future. On a daily basis, we experience physical, chemical and emotional stress that can accumulate and result in a serious loss of health potential. Most times the effects are gradual and are not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

YOUR CHILDHOOD YEARS

Research shows that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

	YES	NO	UNSURE	COMMENTS
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you fallen/jumped from a height over three feet (i.e. crib, bed, trees)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there any prolonged use of medications such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any other traumas (physical or emotional)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
As a child, were you under regular Chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

