



Harrison Chiropractic & Wellness
2828 West 4700 South Suite A · Taylorsville UT 84118
(801)966-3101 · Fax (801)966-0161

PERSONAL INFORMATION:

Name: _____ Date: _____

Address: _____ City: _____ State: _____

Zip: _____ Male: _____ Female: _____ Single Married Divorced Widowed

Your DOB: _____ Age: _____ Spouses Name: _____

Home Phone(____)____-____ Work Phone(____)____-____

Cell Phone (____)____-____ Can we text you at this number? Yes No

Email Address: _____ Referred By: _____

of Children, Names and Ages: _____

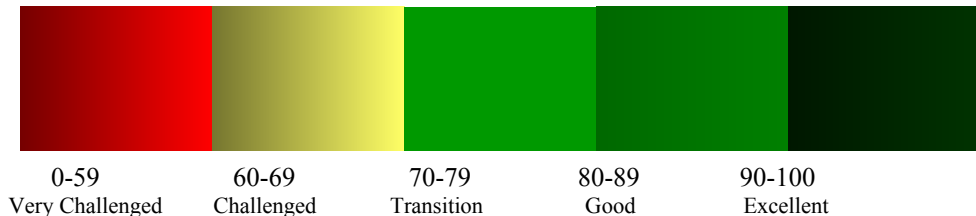
Occupation: _____ Employer Name: _____

Primary Insurance: _____ Policy Holder: _____

Insured DOB: _____ Insured Employer Name: _____

YOUR HEALTH:

Please place an X on the scale marking where you believe your level of health and wellness is at this time. Place a circle (o) on the diagram indicating where you would like your health and wellness to be.



YOUR HEALTH PROFILE:

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or complaints and are here for Chiropractic Wellness Services please skip to the General History page.

Rate the severity from 1-10 _____

When did this start? _____

Are the symptoms constant or intermittent?

Did this problem begin with an injury, if so what kind _____

Since the problem started, it is ____ The Same ____ Getting Better ____ Getting Worse

What makes the problem worse? _____

What, if anything makes it feel better? _____

Does this interfere with your: ____ Work ____ Leisure ____ Sleep ____ Sports ____
Other: _____

Have you seen other doctors for this condition? ____ Chiropractor ____ Medical Dr. ____ Other

Name/ Address: _____

Date: _____ What was the diagnosis? _____

Name/ Address: _____

Date: _____ What was the diagnosis? _____

General History:

List all medications you are taking and why: (Prescription and non-prescription)

Have you had any surgeries or hospitalizations? (Please include all surgeries)

What do you do for a living? _____

Have you ever had any work related injuries? _____

Have you ever had any slips, falls or Auto Accidents?

Please check (✓) symptoms you have had in the last 6 months, even if they do not seem related to your current problem:

- Headaches Pins and needles in legs Fainting Neck pain Fatigue
- Loss of Smell Pins and needles in arms Back Pain Loss of balance Urinary Problem
- Dizziness Numbness in fingers Buzzing in ears Nervousness Irritability
- Loss of taste Numbness in toes Upset Stomach Heartburn Constipation
- Diarrhea Sleeping problems Tension Stiff Neck Depression
- Cold Hands Cold Feet Ringing in ears Lights bother eyes Fever
- Ulcers Menstrual Irregularity Hot Flashes Cold Sweats Mood Swings
- Menstrual Pain

On a scale of 1-10 describe your psychological/emotional stress levels: (1= none - 10=extreme)
 Occupational: _____ Personal: _____

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:
 Eating habits: _____ Exercise habits: _____ Sleep: _____ General Health: _____ Mind-set: _____

YOUR GOALS:

At our office we concern ourselves with YOUR health and YOUR wellness goals. Please list your goals for your health and wellness in the spaces provided.

Physical Goals	Nutritional/ Biochemical Goals	Psychological Goals

Have you ever:

- Bought bottled water: Yes No
- Belonged to a health club: Yes No
- Consumed vitamins or supplements Yes No
- If there is a need for dietary changes would you like to know? Yes No
- If there is a need for specific exercises would you like to know? Yes No
- If there is a need for support in the psychological/mind/body/stress dimension of health would you like assistance?
 Yes No
- Do you smoke Yes No
- Do you drink alcohol Yes No

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature _____ Date: _____

Thank you for filling out this form. It is your first step to creating wellness!

