



Health From Within
Chiropractic • Nutrition • Fitness • Family

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Adult

Wellness Profile and
Application for Care

Practice Member Information _____

File _____

Name: _____

Appointment Date: Month _____ Day _____ Year _____ Birth Date: Month _____ Day _____ Year _____

Home Address: _____

Home Phone: _____ May we leave a message? Yes No

Cell Phone: _____ May we leave a message? Yes No

Work Phone: _____ May we leave a message? Yes No

Email: _____

May we send you text messages as a method of communication? (Your cell phone# will not be shared)

Yes No If 'Yes' - Cell phone carrier company: _____

May we add you to our email newsletter and calendar of events? Yes No (Your email will not be shared)

Spouse's name? _____

Name(s) and age(s) of children: _____

Your occupation: _____

Do you primarily: Sit Stand Perform repetitive tasks Perform heavy manual labor

How did you hear about us? _____

Healthcare History

Have you had previous chiropractic care? No Yes

Who was your previous Chiropractor? _____

Where? _____ When? _____

Were X-rays taken in the last 6 months? Yes No

What was the primary reason for consulting that office?

Relief Care - Symptom relief of pain or discomfort

Corrective Care - Correcting, relieving and stabilizing spinal, joint and postural issues

Wellness Care - Maximizing the body's ability for optimal healing and function

Do you feel your previous chiropractic care was effective? No Yes

Please explain: _____

Are you wearing: Heel Lifts Custom Orthotics

Family Doctor: _____

Date and reason of last visit: _____

May we contact your family doctor regarding your care at our office if necessary? No Yes

Naturopathic Doctor: _____

Date and reason of last visit: _____

Other Specialists and healthcare professionals:

Name: _____

Professional Designation: _____

Date and reason of last visit: _____

Name: _____

Professional Designation: _____

Date and reason of last visit: _____



Wellness Profile

Do you have a specific concern that brings you in?

No, I'm interested in having my nervous system assessed to achieve optimal health and functioning.

Yes: _____

If yes, please answer the following questions:

What is your primary area of complaint today? _____

Was there a specific injury or event that brought this primary complaint on? _____

Do you have any additional complaints besides your primary complaint? Second _____ Third _____

On a scale of 1-10 with 10 being the worst pain and zero being no pain, rate your primary and other complaints:

1st: 1 2 3 4 5 6 7 8 9 10 **2nd:** 1 2 3 4 5 6 7 8 9 10 **3rd:** 1 2 3 4 5 6 7 8 9 10

How long have you been aware of this? _____ days _____ weeks _____ months years

Where else does this pain go in your body? _____

How often do you experience this? daily weekly monthly comes and goes constantly

How would you describe the pain/discomfort?

Dull Achy Throbbing Stabbing Tight/Stiff Burning Sharp Other _____

Do you notice any other problems in your body when you get this pain/discomfort? _____

Do you feel your condition getting progressively worse? No Yes

Do you feel your condition can heal? No Yes

What have you tried that **has** helped? Ice Heat Medication Massage Physical Therapy Chiropractic

Other _____

What have you tried that **hasn't** helped? Ice Heat Medication Massage Physical Therapy Chiropractic

Other _____

See additional **Spinal Nerve Function Form** to provide further detail on your *Wellness Profile (Page5)*

Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate nervous system. The result is a condition called a **Vertebral Subluxation**. The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine which may be impeding your body's ability to heal.

Physical

Height _____ Weight _____

Are you happy with your current physical appearance, body weight, and abilities? Yes No

If 'No', what would specifically make you happy about this area of your health? _____

Frequency of exercise/week: Cardio? 0 1 2 3 4 5 6 7

Resistance training? 0 1 2 3 4 5 6 7

Do you stretch after exercise or after other activities of poor posture? Yes Sometimes No

Hours of sleep/night? >6 7-9 10+

Do you feel refreshed upon waking? Always Sometimes Rarely

Age of mattress? _____ Do you feel your mattress is appropriate for your sleeping style? No Yes

Which position do you sleep? Back Belly Side: Right Left Both

Number of hours spent commuting/week? 0-2 3-5 6-8 9-11 12+

Number of hours spent at a desk or computer/week? 0 1-5 6-10 11-20 21-40 41+

Number of hours spent on smart device/tablet/week? 0 1-5 6-10 11-20 21-40 41+

Do you perform any repetitive tasks at home or at work? No Yes

Have you ever been hospitalized or had surgery? No Yes If yes why and when? _____

Have you ever been in a motor vehicle accident (even if it was minor)? No Yes

If yes, what kind and when? _____

Were you evaluated and treated after each accident? No Yes

Have you had any non-vehicle accidents or falls? No Yes _____



Early Years

To your knowledge, was your birth process difficult and/or did it involve any interventions? No Yes
 If yes: Forceps Vacuum Caesarean Breech Other _____
 Were you breast fed? No Yes For how long? _____
 Did you experience emotional trauma as a child? No Yes _____
 How many times were you given antibiotics as a child that you remember? 0 1-3 5+
 Did you ever have ear infections as a child? No Yes _____
 Any major childhood illness? No Yes _____

Emotional

Rate your current level of **personal stress** in your life: None Low Moderate High
 Rate your current level of **relationship stress** in your life: None Low Moderate High
 Rate your current level of **financial stress** in your life: None Low Moderate High
 Rate your current level of **health stress** in your life: None Low Moderate High
 Rate your current level of **family stress** in your life: None Low Moderate High
 Rate your current level of **career stress** in your life: None Low Moderate High
 Do you feel you have a supportive network of friends and family? . . . Yes No
 Do you feel you have healthy coping strategies for life stress? Yes No
 Do you feel your spiritual health is strong? Yes No

Chemical

Were you vaccinated as a child? No Yes
 Any adverse reactions to vaccines? No Yes _____
 Do you choose to have annual flu shots? No Yes
 Do you take antibiotics? No Yes, How often? _____
 How many glasses of water/day: 0 1-3 4-6 7-9 10+
 How many glasses of caffeinated beverages/day: 0 1-3 4-6 7-9 10+
 How many glasses of cow's milk, juice and pop/day: 0 1-3 4-6 7-9 10+
 Do you eat gluten? No Yes Trying to eliminate from diet
 Do you eat dairy? No Yes Trying to eliminate from diet
 Do you eat refined sugars? (white sugar, white bread and pasta) No Yes Trying to eliminate from diet
 Do you eat boxed/frozen foods? No Yes Trying to eliminate from diet
 Do you choose organic foods? No Yes, which: Veggies Fruits Meats Grains All
 Do you eat any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc) No Yes
 Any food/drink allergies, sensitivities, intolerances? No Yes _____
 Do you smoke? No Yes I used to for__ years I wish I didn't
 Are you or have you been exposed to second hand smoke? No Yes
 Do you drink alcohol? No Yes 0-6/week 6-12/week 12+/week
 Do you take a probiotic daily? No Yes, _____ CFU's/day
 Do you take vitamin D3 daily? No Yes, _____ IU's/day
 Do you take Omega 3 Fish Oils daily? No Yes, _____ mg/day Capsule Liquid
 Other supplements or homeopathics? _____
 Any other daily medication and their purpose? _____

Do you and your medical doctor have a plan in place to reduce &/or eliminate any long term medications? No Yes



SPINAL NERVE

ORGANS & GLANDS

The organs and glands listed below are linked to the corresponding sections of the spine and it's spinal nerves.

ASSOCIATED SYMPTOMS

Please indicate below any symptoms you are currently experiencing as well as any you have previously experienced.

SPINAL NERVE	ORGANS & GLANDS	ASSOCIATED SYMPTOMS	
		CURRENT	PREVIOUS
C E R V I C A L C1 C2 C3 C4 C5 C6 C7 C8 <hr/> T1 T2 T3 T4 T5 T6 T7 <hr/> T8 T9 T10 T11 T12 <hr/> L1 L2 L3 L4 L5 <hr/> S1 S2 S3 S4 S5	Parotid Gland • Scalp Base of Skull • Eyes Lacrimal Gland • Sinuses Inner, Middle & Outer Ear Nose • Mouth Intracranial Blood Vessels Sympathetic Nervous System Neck Muscles • Diaphragm Shoulders • Elbows • Arms Wrists • Hands & Fingers Tonsils • Vocal Cords Esophagus • Heart Lungs • Chest • Thyroid	Sinus & Ear Pain/Infection Runny Nose & Allergies Frequent Head Colds Sore Throat & Tonsilitis Strep Throat Chronic Cough & Croup Difficulty Breathing Poor Immunity Dizziness & Vertigo Tinnitus & Ear Fullness Vision Problems Watery/Dry Eyes Chronic Fatigue Poor Concentration Depression	Anxiety & Stress Seizures ADD/ADHD Thyroid Dysfunction Metabolic Dysfunction Insomnia High/Low Blood Pressure Enlarged Lymph Glands Migraines & Headache TMJ Pain Stiff Neck Arm Pain Hand/Finger Numbness Loss of Grip Strength
	Arms • Wrists Esophagus • Chest • Heart Lungs • Trachea • Larynx Diaphragm • Stomach Gallbladder • Liver Pancreas • Small Intestine Spleen • Kidneys • Appendix Adrenals • Colon • Buttocks Uterus • Ovaries • Testes	Asthma Bronchitis & Pneumonia Congestion Reflux & GERD Indigestion & Heartburn Stomach Pains Ulcers Gas & Bloating Jaundice Liver Conditions Blood Sugar Dysregulation	Kidney Stones Gall Bladder Attacks Skin Conditions & Rashes Menstrual Cramps/PMS Infertility Menstrual Dysfunction Rashes & Eczema Hyperactivity Shoulder Pain Midback Pain Rib Pain
	Large Intestine • Colon Thighs • Buttocks • Groin Knees • Legs • Feet Reproductive Organs	Irritable Bowel, Colitis, Crohn's Gas Pain & Constipation Diarrhea Hemorrhoids Bladder Infections Bladder Incontinence & Bedwetting Painful/Excessive Urination	Prostate Dysfunction & Impotence Ovarian Cysts & Endometriosis Fertility Problems/ Loss of Menstruation Low Back Pain Hip Pain Thigh Pain Numbness & Tingles in Legs
	Buttocks • Groin • Legs Ankles • Feet • Toes Prostate Gland • Bladder Reproductive Organs	Varicose Veins Leg Cramping Restless Legs Poor Circulation & Cold Feet	Sciatica Pelvic Pain Knee Pain Ankle Pain & Sprains Foot Pain & Weak Arches



Daily Activities: Effects of Current Conditions On Performance

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Bending.	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Concentrating	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing Computer Work	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Gardening	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Playing Sports	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Recreation Activities	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Shoveling	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sleeping.	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Watching TV	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Carrying	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dancing.	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Dressing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Lifting.	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Pushing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Rolling Over	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting.	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Working	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Climbing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Doing Chores	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Driving	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sexual Activity	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Reading.	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Running.	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Sitting to Standing	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform
Walking.	No Effect	Painful (can do)	Painful (Limits)	Unable to Perform



Family Health

At our clinic we are not only interested in your health and wellness, but also the health and wellness of those that you love. Not to mention it is critical to understand any potential family history of certain conditions in order to best serve you. Please mention below any health conditions or concerns you may have about your:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers/Sisters: _____

Do you have other concerns we should know about? _____

Goals & Consent

It's important for our doctor to know your goals in order to help you achieve them. What are your top health goals?

Short term (6-12 months): _____

Medium term (1-5 years): _____

Long term (5+ years): _____

I hereby authorize payment to be made directly to HEALTH FROM WITHIN for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to HEALTH FROM WITHIN for any and all services I receive at this office.

Consent to Evaluation

I _____ hereby grant permission to receive a chiropractic evaluation including history, spinal scan, examination and x-rays if warranted. Any findings will be communicated before consenting to commencement of treatment, if appropriate.

FEMALES ONLY - By my signature below, I am acknowledging to the best of my ability, I am **NOT** pregnant at the time of this examination.

Consenting Adult's Signature

Date

Doctor's Signature

Date Form Reviewed