

Welcome to TILTON CHIROPRACTIC & Wellness Center

Please fill out in detail.

Today's Date: _____

Name _____ Home Phone: (____)-____ Cell Phone: (____)-____

Address: _____ City _____ State _____ Zip _____

Referred By: _____ Social Security # _____ Date of Birth _____

Occupation: _____ Employer _____ E-mail: _____

Marital Status: (please circle) M S D W Spouses Name: _____

Spouses Occupation: _____ Number of Children and Ages: _____

About YOUR Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. The following questions are designed to uncover the injuries and stress you have endured since birth. This history will show you and your doctor the layers of damage to your nerve system that has resulted in poor health. Following a review of this history and examination, Dr. Trent or Dr. Nicole will outline a course of care to begin to correct these layers of damage and recover you health potential.

Loss of WELLNESS

While some of the following questions may at first appear obvious or unknown, do your best to fill out as accurate as possible.

Table with 3 columns: Question, please circle (Y/N), and Doctor's Comments. Contains two sections of questions: 1. YOUR own birth process and 2. YOUR growth and development.

Please continue on the other side.

3. Current Health Habits:

Did/Do you smoke?	Y	N	_____
Did/Do you drink alcohol?	Y	N	_____
Do you eat healthy foods?	Y	N	_____
As an adult, have you been in any accidents?	Y	N	_____
Have you had organs surgically removed?	Y	N	_____
Do you take prescription or OTC medications?	Y	N	_____
Do you have any vision or hearing problems?	Y	N	_____
Do you exercise regularly?	Y	N	_____
Do you have sleep difficulties?	Y	N	_____
Did or do you have occupational stress?	Y	N	_____
Do you have a hobby that's physically stressful?	Y	N	_____
Do you feel mentally or emotionally stressed?	Y	N	_____
Sleeping posture: <input type="checkbox"/> side <input type="checkbox"/> stomach <input type="checkbox"/> back			_____

PRESENT STATE OF HEALTH/SYMPTOMS

What is your major current symptom? _____

Pain or condition started on: ___/___/___ Do you think you know what started this? Y N

Describe the nature of your condition: Sharp Dull Constant Comes and Goes

What aggravates your condition? _____

What lessens your condition? _____

Is your condition worse at certain times of the day? _____

Is this condition interfering with work? Y N Sleep? Y N Daily routine? Y N Other? _____

Other Doctors seen for this condition: Y N (MD, DO, DC, PT, Specialist). Dr. _____

If any, what home or prescribed treatments have you employed? _____

Are you taking any prescription or over the counter medications? _____

*Please check the boxes that **currently or in your past** apply to you:*

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins and Needles in legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Pins and Needles in arms | <input type="checkbox"/> Numbness in hand/fingers | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Numb toes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hands cold | <input type="checkbox"/> Irritability | <input type="checkbox"/> Restless Legs |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Stomach upset | <input type="checkbox"/> Chest pains | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Constipation | <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Colds or flu | <input type="checkbox"/> Ears ring | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Stiff neck |
| <input type="checkbox"/> Stiff low back | <input type="checkbox"/> Lack of Energy | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Pain in elbow |
| <input type="checkbox"/> Pain in wrist | <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Ankle pain |
| <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Heartburn/Acid reflux | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Pain streaking down arm | <input type="checkbox"/> Pain streaking down leg | <input type="checkbox"/> Visual disturbances | <input type="checkbox"/> Vertigo |

Is there a family history of: Heart Disease Arthritis Cancer Diabetes Other

EMERGENCY CONTACTS: Please provide the names of two people we can reach in case of Emergency:

1. Name: _____ Address: _____
 Phone: _____

2. Name: _____ Address: _____
 Phone: _____