

RENOVATION CHIROPRACTIC HEALTH PROFILE

Name _____ Date ___/___/___ Age _____ Male/Female

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Cell _____ Cell Phone Provider _____

Email Address _____ Date of Birth ___/___/___

Occupation _____ Employer's Name _____

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	Rate of Severity 1 = mild 10 = unbearable	When did this episode start?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____

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

CIRCLE ANY CONDITION YOU HAVE NOW/ HAVE HAD:

STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES

LIST ALL SURGICAL OPERATIONS AND YEARS _____

LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON:

WHEN WAS YOUR LAST AUTO ACCIDENT _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES / NO

IF YOU HAVE, DR. & DATE _____

HAVE YOU EVER BEEN KNOCKED UNCONSCIOUS? YES / NO FRACTURED A BONE? YES / NO

IF YES, PLEASE DESCRIBE _____

OTHER TRAUMA: _____

IF THIS HEALTH PROFILE IS FOR A MINOR/CHILD, PLEASE FILL OUT AND SIGN BELOW

WRITTEN CONSENT FOR A CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR/CHILD _____

I AUTHORIZE DR. JOHN PETTYGROVE AND ANY AND ALL RENOVATION CHIROPRACTIC STAFF TO PERFORM DIAGNOSTIC PROCEDURES, RADIOGRAPHIC EVALUATIONS, 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 RENOVATION CHIROPRACTIC.

DATE

GUARDIAN SIGNATURE

WITNESS SIGNATURE

GUARDIAN'S RELATIONSHIP TO MINOR / CHILD