HEALTH PROFILE

WHY THIS FORM IS IMPORTANT

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 this office, and second, to offer you the opportunity of improved health potential and wellness in the future. On a daily basis we experience **physical, chemical and emotional stresses** that can accumulate and result in serious loss of health potential. Most times the effects are gradual: 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. Remember: Wellness is our ultimate goal!

BIRTH TO AGE 5

Research is showing that many of the health challenges that occur later in our lives have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability. If you are unsure of the answer leave it blank.

	YES	NO	COMMENTS
1.DURING PREGNANCY DID YOUR MOTHER			
Experience any physical trauma (falls, injuries)?	☐	☐	_____
Have any ultrasound/dopplar tones (how many?)	☐	☐	_____
Eat a nutritious and well-balanced diet?	☐	☐	_____
Smoke tobacco? If yes, how many packs per day?	☐	☐	_____
Drink alcohol? If yes, how many drinks per day?	☐	☐	_____
Take any drugs or medicines at any time?	☐	☐	_____
2. YOUR BIRTH PROCESS			
Hospital birth? If not, where?	☐	☐	_____
Was labor induced?	☐	☐	_____
Were any drugs given during labor? If yes, what kind?	☐	☐	_____
Was the delivery "difficult" ?	☐	☐	_____
Were you in a breech position?	☐	☐	_____
Were forceps, pulling or suction used?	☐	☐	_____
3. EARLY DEVELOPMENT			
Did you experience any significant falls before walking?	☐	☐	_____
Did you have any other injuries or falls?	☐	☐	_____
Were you in a "walker" or door swing as an infant?	☐	☐	_____
Were you ever tossed in the air or shaken?	☐	☐	_____
Were you ever spanked or hit?	☐	☐	_____
Were you breastfed? If yes, for how long?	☐	☐	_____
Were you vaccinated? (some/all Did you receive smallpox?)	☐	☐	_____
Were you ever given any drugs or medication, antibioticss?	☐	☐	_____
Did you have any major illnesses up to age five?	☐	☐	_____

Name _____ Date _____