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Today's Date: \_\_\_/\_\_\_/\_\_\_ File#: \_\_\_\_\_ Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Male Female Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SS#: \_\_\_/\_\_\_/\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_-\_\_\_-\_\_\_ Other Phone #: \_\_\_-\_\_\_-\_\_\_ Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_ How Long: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone #: \_\_\_-\_\_\_

Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status: Single Married Divorced Separated Widowed Spouse's Name: \_\_\_\_\_

Emergency Contact? \_\_\_\_\_ Relation: \_\_\_\_\_ Home #: \_\_\_-\_\_\_-\_\_\_ Work #: \_\_\_-\_\_\_-\_\_\_

## **YOUR 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 services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in a 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.

### **THE BEGINNING YEARS (To AGE 17)**

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

#### **YOUR CHILDHOOD YEARS**

	YES	NO	UNSURE		YES	NO	UNSURE
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you suffer any other traumas(physical or emotional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you take / use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	As a child, were you under regular chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you fallen / jumped from a height over three feet? (i.e. crib, bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

#### **COMMENTS**

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#### **ADULT – (18 TO PRESENT)**

	YES	NO		YES	NO
Do / did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Do / did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>
Do / did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Do /did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	On a scale of 1 - 10 describe your stress level: (1 = none / 10 = Extreme)		
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Occupational _____		
			Personal _____		

**On a scale of 0-10 rate the following areas of health:**

**DIET:** \_\_\_\_\_ **EXERCISE:** \_\_\_\_\_ **SLEEP:** \_\_\_\_\_ **GENERAL HEALTH** \_\_\_\_\_

**As an extra benefit to all of our new patients Back to Health Chiropractic is proud to invite you to take part in our monthly health information newsletter. (Your email is not shared and you can cancel at any time.)**

Enter email to receive valuable health information: Email Address: \_\_\_\_\_

## Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check ( ,/ ) here \_\_\_ "Wish to have Chiropractic Wellness Services" and skip to "Family Health Profile." Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

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If you are experiencing pain, is it... Sharp\_\_\_ Dull\_\_\_ Comes and Goes\_\_\_ Travels\_\_\_ Constant\_\_\_  
 Since the problem started, is it... About the same\_\_\_ Getting Better\_\_\_ Getting Worse\_\_\_

What makes it worse? \_\_\_\_\_

Yes, It interferes with... Work\_\_\_ Sleep\_\_\_ Walking\_\_\_ Sitting\_\_\_ Hobbies\_\_\_ Leisure\_\_\_

Other Doctors I have seen for this problem:

Chiropractor \_\_\_\_\_

Medical Doctor \_\_\_\_\_

Other \_\_\_\_\_

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Problems
<input type="checkbox"/>	<input type="checkbox"/>	Upper back pain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Mid back pain	<input type="checkbox"/>	<input type="checkbox"/>	High blood pres.	<input type="checkbox"/>	<input type="checkbox"/>	Muscular incoordination
<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Visual disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/ Upper Arm pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Wrist pain	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst
<input type="checkbox"/>	<input type="checkbox"/>	Hand pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Hip pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disorders	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use / Smoking
<input type="checkbox"/>	<input type="checkbox"/>	Upper leg pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder infection	<input type="checkbox"/>	<input type="checkbox"/>	Drug/alcohol dependency
<input type="checkbox"/>	<input type="checkbox"/>	Knee pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Ankle and foot pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss bladder ctrl	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain / Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Abn wt change	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal replacement

Are you taking any medications? yes no If so, please list: \_\_\_\_\_

List any past serious accidents/Injuries/Surgeries with dates: \_\_\_\_\_

Do you smoke? yes no How much? \_\_\_\_\_ How long? \_\_\_\_\_

FOR WOMEN: Taking birth control: yes no Pregnant? yes no If so, how long? \_\_\_\_\_ Nursing? yes no

The worst negative things that are associated with my lack of health are: \_\_\_\_\_

The best Positive things that will be added to my life when I regain my health will be: \_\_\_\_\_

*The statements made on this form are accurate to the best of my recollection and I agree to allow this office to*

*examine me for further evaluation* Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_