

BENESSERE: Body in Balance

125 Main Street S.E. Suite 237

Minneapolis, MN 55414

612-378-WELL

PATIENT HEALTH PROFILE

Name _____ Today's Date _____
Address _____ Daytime Phone _____
City _____ Cellular Phone _____
State _____ Zip Code _____ E-mail _____
Primary Occupation _____ Birth Date _____
In case of emergency, notify _____
Phone _____ Relationship to you _____
Who can we thank for referring you to our clinic? _____

Your Therapeutic Goals

What is the outcome you most desire as a result of your therapy here? _____

Do you believe that this outcome is possible? Yes _____ No _____ Not sure _____

We define a symptom as "anything you don't like." Examples include physical pain, discomfort, lack of satisfaction in life, etc. The next several questions refer to your symptoms.

o Please identify your most troubling symptoms: _____

When is the first time you remember noticing it? _____

How often does it bother you? Constantly ___ Daily ___ Weekly ___ Occasionally ___

On a scale of 1 (mild) to 10 (severe), how intense is it? _____

How would you describe your pain? Sharp ___ Ache ___ Soreness ___ Stiffness ___

Dull ___ Weakness ___ Throbbing ___ Spasm ___ Numbness ___ Tingling ___ Burning ___

Shooting ___ Stabbing ___

Since it began is the pain: Getting worse ___ Getting better ___ Staying the same ___

How did your problem begin? _____

What makes your problem better? _____

What makes your problem worse? _____

How long does it last? _____

What do you think is causing it? _____

What treatments have you received for this condition? _____

o If you have a second symptom, please identify it? _____

When is the first time you remember noticing it? _____

How often does it bother you? Constantly ___ Daily ___ Weekly ___ Occasionally ___

On a scale of 1 (mild) to 10 (severe), how intense is it? _____

How would you describe your pain? Sharp ___ Ache ___ Soreness ___ Stiffness ___

Dull ___ Weakness ___ Throbbing ___ Spasm ___ Numbness ___ Tingling ___ Burning ___

Shooting ___ Stabbing ___

Since it began is the pain: Getting worse ___ Getting better ___ Staying the same ___

How did your problem begin? _____

What makes your problem better? _____

What makes your problem worse? _____

How long does it last? _____

What do you think is causing it? _____

What treatments have you received for this condition? _____

Please describe any additional symptoms that bother you: _____

Your Health History

When did you last see a medical doctor for your condition? _____

What was the diagnosis? _____

Who is your medical doctor? _____

Are you under the care of a chiropractor? ____ If so, who? _____

Are you under the care of a mental health professional? ____ If so, who? _____

Please mark any of the following conditions that you have or have had at any time:

- | | | |
|---|---|---|
| <input type="checkbox"/> Past or Present | <input type="checkbox"/> Past or Present | <input type="checkbox"/> Past or Present |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Past Pregnancies (#)____ |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Infectious Diseases | <input type="checkbox"/> Ringing in ears/tinnitus |
| <input type="checkbox"/> Caffeine Consumption | <input type="checkbox"/> Immune system problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental health problem | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Skin problems or rash |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sleep disorders |
| <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Dizziness or vertigo | <input type="checkbox"/> Pain or discomfort in: | <input type="checkbox"/> Soda pop consumption |
| <input type="checkbox"/> Drug or alcohol use | <input type="checkbox"/> Back | <input type="checkbox"/> Spinal problems |
| <input type="checkbox"/> Emotional Disorders | <input type="checkbox"/> Neck | <input type="checkbox"/> Sugar consumption |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Head (headaches) | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Eye conditions | <input type="checkbox"/> Arms or shoulders | <input type="checkbox"/> TMJ dysfunction |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Legs or hips | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Hands or Feet | <input type="checkbox"/> Tuberculoses |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Varicose veins |

Please list your prescribed medications (attach a separate page if you prefer):

- Medication _____ Condition Treated _____
- Medication _____ Condition Treated _____
- Medication _____ Condition Treated _____
- Medication _____ Condition Treated _____

What non-prescribed medicines or supplements do you take regularly? _____

- Do you have a pacemaker? ___ yes ___ no
- Do you wear orthotics (shoe inserts)? ___ yes ___ no
- Do you wear glasses or contact lenses? ___ yes ___ no
- Are you taking Coumadin/Warfarin or Lithium ___ yes ___ no
- Any dental appliances (dentures, bite splints, etc.)? ___ yes ___ no
- Are you allergic to latex? ___ yes ___ no

List any other allergies: _____

Describe any surgeries or hospitalizations, even if they were years ago: _____

Other activities, hobbies, sports _____

Describe any accidents, even if they were years ago. Include athletic injuries, falls, etc., in addition to motor vehicle accidents: _____

Exercise, other activities, hobbies, sports _____

I have read and completed the health profile to the best of my ability.

Date: _____

 Your signature; or the signature of your parent or guardian if you are under 18 years of age