Inspired Life
CHIROPRACTIC

Dr. Heidi Wroebel, DC

Adult Health Profile

Welcome to our office! Congratulations on taking the first step towards investigating new options for your health and full self-expression. Our goal is to serve you and your family to the best of our ability; filling out this form thoroughly aids us in that important process.

Name: SS# (Optional): Today's Date:

Home Address: City: State: Zip:

Home phone: ( ) Work Phone: ( ) Cell Phone: ( )

Date of Birth: Age: Sex: Male / Female Marital Status: S M D W

Name of Partner**:** Names & Ages of Children**:**

Occupation: Employer & Business Address:

Email Address: Emergency Contact & Phone #:

Whom may we thank for referring you to our office?

Have you ever had your Spine and/or Nervous System evaluated professionally? **Y N**
If yes, with whom? _____
Have you ever been to a Chiropractor? **Y N**
If yes, please describe the type of technique or method he/she used and how was your experience and results?
_____
What is the name & number of your family doctor? _____
Date of last medical consultation & result _____
Has anyone in your family suffered a serious illness or health condition? _____
_____
What is your motivation in seeking care in this office? _____
What do you hope to get out of our consultation & examination? _____

IF WE DO ACCEPT YOUR CASE for care, because we are confident we can help you, are there any reasons why you cannot complete the doctor's recommendations for recovery and health preservation? If so, please explain _____
If all barriers/obstacles were taken down for you and your family would your well-being and fulfillment of your complete self-expression be your main priority?_____

CURRENT HEALTH CONCERN

Why are you seeking care? Please specify what symptom/concern/condition that you are coming in for and/or what life and/or wellness goals you seek _____

_____

When did this symptom or concern begin? _____

Have you done anything about this or received any advice or treatment for it? **Y N** If yes, please describe

_____

Are there any daily activities, hobbies, relationships, or work performance that this symptom(s)/concern/condition interferes with and how so? _____

_____

If this symptom/condition/concern were to go away tomorrow, what would be different in your life?

_____

What new possibilities would be available to you and would you like to create for yourself if you were fully well, healthy, and self-expressed? _____

How do you FEEL about your current condition? (If you do not have a health concern, then state how you feel about your life.) Please choose **ONE** answer that **BEST** describes how you feel:

I feel helpless; nothing works.
I don't like what I'm feeling, and I hope you can fix it.
I feel this is a pattern that has happened to me before; it is back again.
I feel there is a message my body is giving me.
I am looking for assistance in becoming healthier so I can move past my health concern.
I realize my condition may be a necessary experience in getting to the real problem.
I don't know how I feel. I am too preoccupied with my present condition.
I am looking for something to help me enhance my quality of life and to further enhance my life expression.

HISTORY OF PHYSICAL STRESSES

Were there any difficulties associated with your mother's pregnancy or your birth? **Y N** If yes, please describe _____

Have you had an accident or near accident, even as a passenger, in a(n): (check all that)

□Automobile □Motorcycle □Bus □Bicycle □Train □Plane □Other_____

Explain all with dates _____

_____

What sports did you play in the past and when? _____

_____

What are your current hobbies and sports that you participate in? _____

_____

Medical Past & Present Interventions: (check all that apply)

□Hospitalization □Surgery □Chemotherapy □Cast/Collars □Traction □Organ/Body Part Removal
□Extensive X-rays □Physiotherapy □Spinal Tap □Shoe Lifts □Other_____

Explain with dates _____

_____

Please check all that apply & note dates of the below listed potential causes of Spine / Nervous System stress: FALLS: □From Crib_____ □Tree_____ □Bicycle_____ □Steps_____ □Skates____ □On Ice_____

□Physical Fight_____ □Armed Forces_____ □Abuse_____ □Childhood illness_____
□Broken Bones_____ □Crutch/Cane_____ □Major Dental Work_____ □Other_____
Description and Comments _____
_____

Have you ever been knocked unconscious? **Y N** Have you ever sustained any head injuries? **Y N**
Explain with Dates _____

Please describe daily routine activities for work, home, or school (i.e. sitting, computer use, lifting, standing, phone use, driving a vehicle, playing an instrument, etc) _____
_____

FOR WOMEN ONLY: Please describe your pregnancies & labors with dates and any complications or difficulties you experienced _____
_____
Were you given an epidural during any labor or deliveries? **Y N**
Are you pregnant? **Y N** Date of last monthly period_____ Are your periods irregular / painful? **Y N**
If you are in menopause or peri-menopausal, please describe any symptoms you're experiencing _____
_____

HISTORY OF CHEMICAL STRESSES
Have you been vaccinated? **Y N**
Please list any drugs you are currently taking (prescription, over-the-counter, or recreational) _____
_____
Please check all that apply & note dates of the below listed potential causes of Spine / Nervous System stress:
In the past have you taken: □Prescription drugs □Over-the-Counter Drugs □Antibiotics □Other
Do you or have you ever worked with: □Chemicals □Fumes □Dust □Smoke
Do you consume: □Alcohol □Coffee/Caffeine □Tobacco □Refined Sugar
□Artificial Sweeteners
Description and Comments _____
Please describe your eating habits (to include your water intake, fresh fruits & veggies, etc) _____
_____

HISTORY OF EMOTIONAL STRESSES
Please check all that apply & note dates of the below listed life stresses and potential causes of Spine / Nervous System stress: (Please also note their severity on a 1-5 scale; 1 is the easiest and 5 is the most difficult.)
□Childhood____ □Loss of Loved One____ □Recreation____ □Family____ □Work____ □Abuse____
□Stress of Illness____ □Relationships____ □Commuting____ □School____ □Financial □Parents divorce___
□Separation/Divorce_____ □Lifestyle change_____ □Other____
Description and comments _____
_____

Have you ever been diagnosed or treated for the following conditions? Please note the dates also.
□Cancer____ □Heart Disease____ □Diabetes____ □AIDS/HIV____ □Stroke____ □Severe Depression____
□Arthritis____ □Allergies____ □Scoliosis____ □Anxiety____ □TMJ____ □Other_____
Please explain with dates and also describe anything else not listed above _____

How do you grade your physical health?
□Excellent □Good □Fair □Poor My physical health is currently: □Getting Better □Getting worse

How do you grade your emotional/mental health?
□Excellent □Good □Fair □Poor My emotional/mental health is currently: □Getting Better □Getting worse

How do you rate your overall quality of life?
□Excellent □Good □Fair □Poor It is currently: □Getting Better □Getting worse

How well do you rate your ability to deal with and adapt to Stress?
□Excellent □Good □Fair □Poor It is currently: □Getting Better □Getting worse

OVERALL HEALTH

Do you participate in any of the following Healthy Lifestyle Behaviors:
□Regular Exercise □Organic/Healthy □Filtered Water □Anti-oxidants □Prayer/Meditation
□Massage □Supplements/Vitamins_____
□Other_____

What would you like more of in your life?
□More energy □Regulate my stress better □Better relationships with family, friends, & peers
□Improved Concentration □Motivation for better life choices □Sense of well-being & fulfillment
□Less anxiety/more ease □More positive feelings □More richer, satisfying life
□Improved physical health □Improved mental/emotional Health

Which are you most interested in? □Crisis and emergency care □Wellness and emergency care

What would motivate you to tell others about the care you receive in this office and encourage others to get in care? _____

Is there anything else you wish to share which may help us to better understand you, and why you have chosen to come into this office? _____
_____

INFORMED CONSENT & PAYMENT

I hereby request and consent to the performance of evaluations, diagnostic testing, chiropractic adjustments or "entrainments", and other Chiropractic/Rehabilitative/Healing procedures, including possible breath work, by Dr. Wroebel and any other licensed doctors of Chiropractic who work with Dr. Wroebel or cover her practice, now and in the future.

I understand that payment is expected at the time of service unless other payment arrangements have been made in advance. I also understand that if I terminate or suspend my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature_____ Today's Date_____