

**Please check all symptoms you have had in the past year, even if they do not seem related to your current problem.**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Pins & needles in legs | <input type="checkbox"/> Fainting                | <input type="checkbox"/> Neck pain       |
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Loss of smell          | <input type="checkbox"/> Back Pain               | <input type="checkbox"/> Loss of balance |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Buzzing in ears        | <input type="checkbox"/> Ringing in ears         | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Numbness in fingers    | <input type="checkbox"/> Numbness in toes       | <input type="checkbox"/> Loss of taste           | <input type="checkbox"/> Stomach upset   |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Depression             | <input type="checkbox"/> Irritability            | <input type="checkbox"/> Tension         |
| <input type="checkbox"/> Sleeping problems      | <input type="checkbox"/> Neck stiff             | <input type="checkbox"/> Cold hands              | <input type="checkbox"/> Cold feet       |
| <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Constipation           | <input type="checkbox"/> Fever                   | <input type="checkbox"/> Hot flashes     |
| <input type="checkbox"/> Cold sweats            | <input type="checkbox"/> Lights bother eyes     | <input type="checkbox"/> Problem urinating       | <input type="checkbox"/> Heartburn       |
| <input type="checkbox"/> Mood swings            | <input type="checkbox"/> Menstrual pain         | <input type="checkbox"/> Menstrual irregularit__ | <input type="checkbox"/> Ulcers          |

List any medications you are taking \_\_\_\_\_  
 \_\_\_\_\_

As your chiropractic office we are not only interested in your health and well-being, but also the health of your spine and nervous system. As your wellness center, we provide other services as well. Please indicate your interests by circling below.

- |                                  |                                    |
|----------------------------------|------------------------------------|
| Health without Medications       | Alternative Medicine               |
| Diet (Secrets of Healthy Living) | Education (Research & Newsletters) |
| Weight Loss                      | Exercise                           |
| Improved Nutrition               | Massage                            |

**Have you ever:**

- |                                  |  |
|----------------------------------|--|
| Bought bottled water             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Belonged to a health club        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Consumed vitamins or supplements | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**What aspects of wellness do you want for yourself?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> More energy                      | <input type="checkbox"/> Better sleep   | <input type="checkbox"/> Freedom from pain               |
| <input type="checkbox"/> Better concentration             | <input type="checkbox"/> Enhanced emotional well-being                        | <input type="checkbox"/> Reduce/eliminate medication use |
| <input type="checkbox"/> Improved digestion               | <input type="checkbox"/> Improved strength & endurance                        | <input type="checkbox"/> Greater resistance to disease   |
| <input type="checkbox"/> Deeper relaxation                | <input type="checkbox"/> Better sports performance,<br>reaction time/reflexes | <input type="checkbox"/> Overall health improvement      |
| <input type="checkbox"/> Easier breathing, deeper breaths | <input type="checkbox"/> More balanced posture                                |  |