



Living Well

Dr. Cree Guardino
Doctor of Chiropractic

Cindy D. Hernandez
LMT, CST and Reiki Master

Full Name: _____ Date: _____

Social Security Number: _____ DOB: _____ Age: _____ Male / Female (please circle)

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Spouse/Significant Other: _____ DOB: _____ Social Security Number: _____

Children's Names and Ages: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip: _____

Emergency Name and Phone Number: _____

How did you hear about us (please specify name of referral)? _____

Is there a specific reason for consulting our office at this time? _____

Your Health Profile

As a full spectrum office we focus on your ability to be healthy. Our goals are first to address the issues that brought you to the office, and second, to offer you the opportunity for improved health potential and wellness services in the future. On a daily basis, we experience physical, chemical and emotional stress that can accumulate and result in serious loss of health potential. Most times the effects and 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.

Your Childhood Years

Research shows 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.

	Yes	No	Unsure	Comments
Did you have any childhood illness?	<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"/>	
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Did you take/use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	Yes	No	Unsure	Comments
Did you have any surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have you fallen/jumped from a height over 3 ft?	<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"/>	
Was there any prolonged use of medicine (i.e. inhaler)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Did you suffer any other traumas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Were you vaccinated?	<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"/>	

Your Adult Years

	Yes	No	Unsure	
Do you drink water daily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How much:
Do you drink caffeine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How much:
Do/did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How much:
Do/did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How much:
Any surgeries/hospitalizations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do you take any supplements/vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What kind/brand:
Do/did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
On a scale 0-10 describe your stress (0 = none / 10 = extreme):	Occupational:		Personal:	
On a scale of Poor/Good/Excellent describe your:	Diet:	Exercise:	Sleep:	General Health:
Have you ever:	Bought bottled water Y / N (please circle)		Belonged to a health club Y / N (please circle)	

Addressing The Issues That Brought You To The Office

If you have no specific symptoms or complaints, and you are here for Chiropractic and/or Therapeutic Massage please mark (x) here _____ and skip to the Family Profile section of this form. All others, please briefly describe your chief area of complaint (*include the effect it has had on your life*):

Does symptom(s) interfere with: Work Sleep Walking Sitting Hobbies Leisure

If you are experiencing pain, it is: Sharp Dull Comes and goes Travels Constant

Since the problem started, it is: About the same Getting better Getting worse

What makes it worse?

Please indicate who else you have seen for this problem:

Chiropractors: _____

Medical Doctors/Others: _____

Please indicate all symptoms you have had, even if they do not seem related to your current problem:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pins/Needles in Legs | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fever | <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"/> Pins/Needles in Arms | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Buzzing in Ear | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Problem Urinating | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Menstrual Irritability | <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Mood Swing | <input type="checkbox"/> Eyes Sensitive to Light |

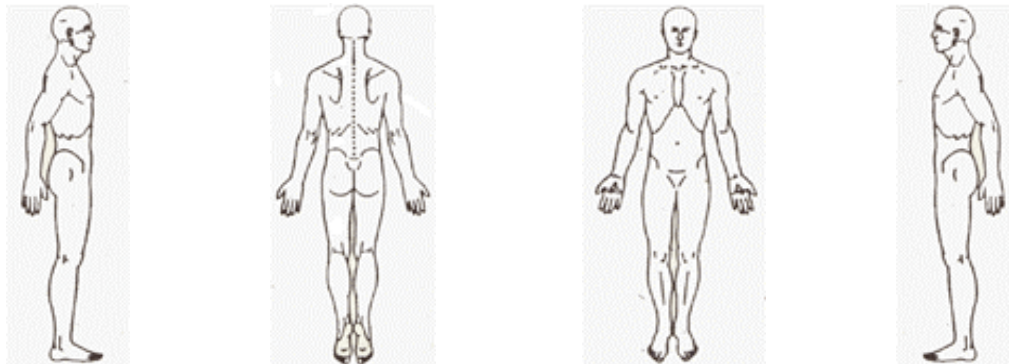
Please indicate the conditions below that have affected your health either recently or in the past.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Headaches | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Skin Conditions | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Broken/Dislocated Bones | <input type="checkbox"/> Stroke | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Surgery | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis (A, B, C, other) |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> TMJ Disorder | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Chemical Dependency |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Muscle Strain/Sprain | <input type="checkbox"/> Auto-Immune Condition |

If any of the above needs to be detailed or if there is anything else you would like to share, please do so here:

Please list any medications you are currently taking:

Please indicate with an (x) the areas in which you are feeling discomfort:



Family Health Profile

We are not only interested in your health and well-being, but also about your family and loved ones. Please mention below any health conditions you may have about you:

Children:

Spouse/Significant Other:

Parents:

Siblings:

Others:

The statements made on this form are accurate to the best of my knowledge.

Signature

Date

Massage Information

Have you ever received massage therapy? Yes No

List the type of massage you have experienced (*Swedish, shiatsu, deep tissue, etc.*):

Are you currently taking any medications? Yes No

If Yes, please list the name and reason for medications:

Are you currently seeing a healthcare professional? Yes No

If Yes, please list names and reason/treatment:

Do you have the following today (*please circle*): skin rash cold/flu open cuts

severe pain anything contagious injuries/bruises

Do you have any allergies to (*please circle*): medications foods (nuts, etc.) skin care products

environmental allergens (dust, pollen, fragrances)

Are you wearing (*please circle*): contact lenses hearing aid hairpiece

What are your goals/expectations for this therapy session:

The following sometimes occurs during massage:

- Need to move or change position
- Sighing, yawning, change in breathing
- Stomach gurgling
- Emotional feelings and/or expression
- Movement of intestinal gas
- Energy shifts
- Falling asleep
- Memories

These are normal responses to relaxation. Trust your body to express what it needs to.

Please read the following information and sign below:

1. I understand that although massage therapy can be very therapeutic, relaxing and reduce muscular tension, it is not a substitute for medical examination, diagnosis and treatment.
2. This is a therapeutic massage and any sexual remarks or advances will terminate the session and I will be liable for payment of the scheduled treatment.
3. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions truthfully.

Signature

Date

Once again, we would like to welcome you to our office.

If you have any questions regarding your health and wellness care please don't hesitate to ask.