



Dr. Mark Haynes
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Personal Information

NAME: _____ AGE: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 MALE FEMALE SINGLE MARRIED DIVORCED WIDOWED
 SOCIAL SECURITY #: _____ BIRTHDATE: _____
 HOME PHONE #: _____ CELL PHONE #: _____
 E-MAIL ADDRESS: _____
 WORK PHONE #: _____ OCCUPATION: _____
 EMPLOYER: _____
 WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE: _____

Your Health Profile

Addressing what brought you to this office

If you have no symptoms or complaints and are here for **Chiropractic Wellness Services**, please skip to the **“General History.”**

Please briefly describe your chief concerns, including the effect it has had on your life.

Health Concerns: List health concerns according to their severity	Rate of Severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did this problem begin with an injury?	Are symptoms constant or intermittent?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

I Do I Do Not have a family history of this or similar symptoms (if you do, please explain)

Is this condition interfering with your: Work Leisure Sleep Sports/Exercise/Walking
 Positive Mental Attitude Hobbies Daily Tasks Other _____

Other Doctors seen for this condition: Chiropractor Medical Dr. Other _____

Name: _____

Date: _____ What was the diagnosis? _____

What was done? _____

Name: _____

Date: _____ What was the diagnosis? _____

What was done? _____

General History:

Please check all symptoms you have ever had and circle symptoms you currently have, even if they do not seem related to your current problem:

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

List any medications you are taking and why: (prescription and non-prescription)

Have you had any surgery?

Type _____ Date _____ Doctor _____

Type _____ Date _____ Doctor _____

Type _____ Date _____ Doctor _____

Accidents and/or injuries: auto, work related or other (especially those related to your present problems).

Type _____ Date _____ Hospitalized Yes No

Type _____ Date _____ Hospitalized Yes No

If you have had x-rays taken in the last 7 years:

When _____ Where _____ Area of body: _____

When _____ Where _____ Area of body: _____

Do you wear orthotics or heel lifts? Yes No

Please circle your top three stresses in each category:

Physical Stress: Falls Accidents Work Postures Sports Lack of Exercise Sleep

Other _____

Bio-Chemical Stress: Smoke Alcohol Medications Non-prescription medications Fast Foods

Processed Food Missed Meals Don't eat enough fruits/vegetables Don't drink enough water

Other _____

Psychological Stress: Work Relationships Finances Low self-esteem Time management

Disorganization Anxiety Depression Lack of goals Excess worrying Inadequate support system

Other _____

On a scale of 1-10, describe your psychological/emotional stress levels: (1 = none/ 10 = extreme)

Occupational: _____ Personal: _____

On a scale of 1-10, (1 being very poor and 10 doing excellent) describe your:

Eating Habits: _____ Exercise Habits: _____ Sleep: _____ General Health: _____ Mind-Set: _____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please list below their names and any health conditions or concerns you may have:

Children: _____

Spouse: _____

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Others: _____

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature: _____ Date: _____

Thank you for filling out this form. It is your first step to **Creating Wellness!**

Return this to our staff and someone will be right with you.