



**ROYAL WELLNESS CENTER**  
9601 White Rock Trail, Suite 225  
Dallas, Texas 75238  
Phone: 214-324-5800/Fax: 214-324-5838

## PERSONAL INFORMATION:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/ Zip: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_ Male \_\_\_ Female \_\_\_ DOB: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_

Best Time To Contact: \_\_\_\_\_ Status: Single Married Divorced Widowed

Emergency Contact Name & Phone Number: \_\_\_\_\_

Number of Children, Names and Ages: \_\_\_\_\_

Referred By: \_\_\_\_\_

## YOUR HEALTH:



Please place an "X" on the scale above marking where you believe your level of health and wellness is at this time. Place a **circle (O)** on the diagram indicating where you would **like** your health and wellness to be.

## YOUR HEALTH PROFILE:

What brings you into our office? Please briefly describe your chief concern, including the impact it has had on your life. If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to the "Childhood History" page.

List Main Health Concerns:	Rate Severity 1 = mild 10 = worst imaginable	When did this start?	Are symptoms Constant or intermittent?	Did problem begin with injury?
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1. \_\_\_\_\_

2. \_\_\_\_\_

Since the problem started, it is... \_\_\_\_\_ The same \_\_\_\_\_ Getting Better \_\_\_\_\_ Getting Worse  
What makes the problem worse? \_\_\_\_\_  
\_\_\_\_\_

What, if anything makes it feel better? \_\_\_\_\_  
\_\_\_\_\_

Does this interfere with your: \_\_\_\_\_ Work \_\_\_\_\_ Leisure \_\_\_\_\_ Sleep \_\_\_\_\_ Sports \_\_\_\_\_  
Other: \_\_\_\_\_

Have you seen other doctors for this condition? \_\_\_\_\_ Chiropractor \_\_\_\_\_ Medical Dr. \_\_\_\_\_ Other  
Name/ Phone number: \_\_\_\_\_  
Date: \_\_\_\_\_ What was the diagnosis? \_\_\_\_\_

Name/ Phone number: \_\_\_\_\_  
Date: \_\_\_\_\_ What was the diagnosis? \_\_\_\_\_

**Childhood History: Circle all that apply**

Did you have any childhood illnesses?	Yes	No
Did you have any serious falls as a child?	Yes	No
Did you play youth sports?	Yes	No
Have you fallen / jumped from a height over three feet?	Yes	No
Were you in any car accidents as a child?	Yes	No
Was there any prolonged use of medicine such as antibiotics or an inhaler?	Yes	No
Did you suffer any other traumas (physical or emotional)	Yes	No
As a child, were you under regular chiropractic care?	Yes	No

**General History:**

Have you had any surgeries or hospitalizations? (Please include all surgeries)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please List any broken bones (fractures) or dislocations \_\_\_\_\_  
\_\_\_\_\_

Have you ever had any work related injuries? If so, please explain \_\_\_\_\_  
\_\_\_\_\_

Have you ever had any slips, falls or auto accidents? If so, please describe \_\_\_\_\_  
\_\_\_\_\_

Were you ever knocked unconscious?      Yes      No

**Adult – (18 to present)**

Do/did you smoke?	Yes	No
Do/did you drink alcohol?	Yes	No
Do/did you play adult sports?	Yes	No
What sport? _____		

**Rate the following as Poor, Good, Excellent:**

General Health: \_\_\_\_\_  
Sleep: \_\_\_\_\_ Hours per day? \_\_\_\_\_  
Exercise: \_\_\_\_\_ When and what? \_\_\_\_\_  
Diet: \_\_\_\_\_ What do you mainly eat? \_\_\_\_\_  
\_\_\_\_\_

**Please check ( ) all symptoms you have in the last 3 months or a (P) next to it if you've ever had the symptom, even if they do not seem related to your current problem:**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches/Migraines      | <input type="checkbox"/> Pins/Needles in Legs or Feet | <input type="checkbox"/> Digestive difficulties | <input type="checkbox"/> Buzzing/ringing in ears |
| <input type="checkbox"/> Fever                    | <input type="checkbox"/> Pins/Needles in Arms/Hands   | <input type="checkbox"/> Heartburn              | <input type="checkbox"/> Loss of smell           |
| <input type="checkbox"/> Dizziness/Vertigo        | <input type="checkbox"/> Numbness in Fingers or Toes  | <input type="checkbox"/> Ulcers                 | <input type="checkbox"/> Loss of taste           |
| <input type="checkbox"/> Loss of Balance          | <input type="checkbox"/> Numbness Elsewhere           | <input type="checkbox"/> Constipation           | <input type="checkbox"/> Nervousness             |
| <input type="checkbox"/> Cold Sweats/Night Sweats | <input type="checkbox"/> Neck Pain or Stiffness       | <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Shoulder Pain                | <input type="checkbox"/> Urinary Problem        | <input type="checkbox"/> Anxiety                 |
| <input type="checkbox"/> Sleeping Problems        | <input type="checkbox"/> Back Pain                    | <input type="checkbox"/> Menstrual Pain         | <input type="checkbox"/> Tension                 |
| <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Weakness                     | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Irritability            |
| <input type="checkbox"/> Allergy/Sinus Problems   | <input type="checkbox"/> Swollen Joints               | <input type="checkbox"/> Menstrual Cramping     | <input type="checkbox"/> Mood swings             |
| <input type="checkbox"/> Cold Hands/Feet          | <input type="checkbox"/> Painful Tailbone             | <input type="checkbox"/> Excessive Flow         | <input type="checkbox"/> Loss of Weight          |
| <input type="checkbox"/> Frequent Colds           | <input type="checkbox"/> Foot Trouble                 | <input type="checkbox"/> Miscarriage            | <input type="checkbox"/> Weight Gain             |
| <input type="checkbox"/> Difficulty Breathing     | <input type="checkbox"/> Eczema or skin problems      | <input type="checkbox"/> Hot Flashes            | <input type="checkbox"/> Lights bother eyes      |

**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 being excellent) describe your:**

Eating habits: \_\_\_\_\_ Exercise habits: \_\_\_\_\_ Sleep: \_\_\_\_\_ General Health: \_\_\_\_\_ Mind-set: \_\_\_\_\_

**YOUR GOALS:** At our office we concern ourselves with YOUR health and YOUR wellness goals. Please list your goals for your health and wellness in the spaces provided.

**Physical Goals**

**Nutritional/ Biochemical Goals**

**Psychological Goals**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Family Health Profile:**

At our office we are not only interested in your health and wellbeing but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: \_\_\_\_\_  
Spouse: \_\_\_\_\_  
Mother: \_\_\_\_\_  
Father: \_\_\_\_\_  
Brother(s): \_\_\_\_\_  
Sister (s): \_\_\_\_\_  
Others: \_\_\_\_\_

**Have you ever:**

- Bought bottled water:  Yes  No
- Belonged to a health club:  Yes  No
- Consumed vitamins or supplements  Yes  No
- If there is a need for dietary changes would you like to know?  Yes  No
- If there is a need for specific exercises would you like to know?  Yes  No
- If there is a need for support in the psychological/mind/body/stress dimension of health would you like assistance?  Yes  No

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.