Harold Turk D.C.

Maori-trained Healer & Body Therapy • Doctor of Chiropractic
Health, Body & Life Coach

Name: _____

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

Email: _____ Phone: _____

Birthdate (MM/DD/YY): / / Age: _____ Height: _____ Weight: _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed Name of spouse (or parent): _____

Names & ages of children: _____

Profession/Employer: _____

Name, phone number & location of your primary physician: _____

Have you ever had Chiropractic care before? ☐ Yes ☐ No

If so, name of Doctor & last visit: _____

In the order of importance to you, please list all areas of your life that you are needing help with (physical and/or emotional pain, relationship/money/career issues?):

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

Have any of these problems been getting worse? ☐ Yes ☐ No If so, which ones? _____

Do you feel your physical health issues are caused or contributed to by mental ones? ☐ Yes ☐ No

If so, how do you feel it does? _____

How motivated are you in dealing with these issues? _____

What factors might cause you to **not** be able to deal with the things you've listed above?

_____

Have you ever had ANY surgeries or hospitalizations? ☐ Yes ☐ No

If so, please list: _____

Please list any past or current physical injuries, illnesses or trauma not listed above:

_____

Please list all medications you are currently taking:

☐ Aspirin/Tylenol ☐ Pain killers ☐ Muscle relaxers ☐ Insulin ☐ Birth control ☐ Sleeping pills

☐ Anti-depressants/Anxiety medications ☐ Others (please list): _____

Please share a little bit of information that describes how the things you listed on the front side of this form (1-4) affects the major stress areas of your life.

Stress area 1: _____

How is it affected? _____

_____

_____

Stress area 2: _____

How is it affected? _____

_____

_____

Stress area 3: _____

How is it affected? _____

_____

_____

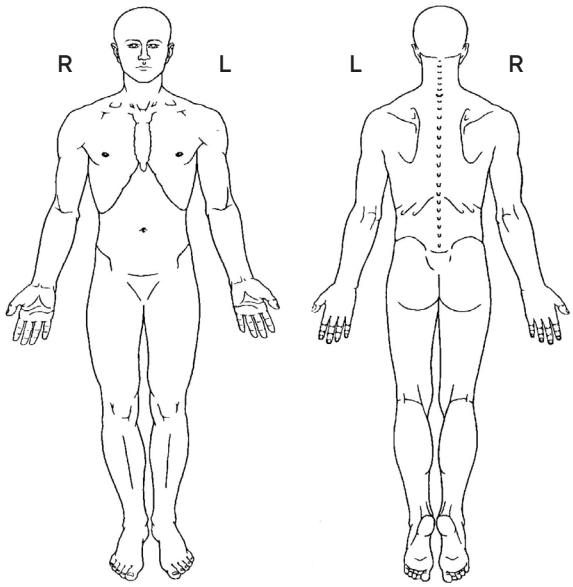
Stress area 4: _____

How is it affected? _____

_____

_____

If you are experiencing any body pain,
please mark the exact location on this diagram.
Also, describe the type and frequency of your pain.
For example: dull, sharp, constant, off and on,
when standing, sitting, walking, etc.



Signature: _____

Date (MM/DD/YY): _____

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Private Coach
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