

**Personal and Family Health History**

Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Phone: (H) \_\_\_\_\_

Phone: (work) \_\_\_\_\_

Phone: (cell) \_\_\_\_\_

Date of Birth \_\_\_\_\_ (Age \_\_\_\_\_)

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_, Relationship \_\_\_\_\_, Phone \_\_\_\_\_

Do you have Health Insurance? Y N Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Have you ever been to a chiropractor? Y N If so, list Dr.'s Name: \_\_\_\_\_ When Visited: \_\_\_\_\_

Reason: \_\_\_\_\_ Results: \_\_\_\_\_

Are you currently under medical care? Y N Dr.'s Name: \_\_\_\_\_ For condition: \_\_\_\_\_

List Current Medications and/or Supplements: \_\_\_\_\_

List any broken bones and/or surgeries and dates: \_\_\_\_\_

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

**1. Was Your Birth Traumatic?**

Long Delivery?	Y / N
Difficult Delivery?	Y / N
Forceps?	Y / N
Caesarian?	Y / N
Breach/cephalic?	Y / N
Home birth?	Y / N
Mother given drugs during delivery	Y / N
Induced Labor?	Y / N

**2. Growth and Development**

Did you ever . . .	
Fall out of bed?	Y / N
Bang your head?	Y / N
Experience other traumas?	Y / N
Have any accidents?	Y / N
Have childhood sicknesses?	Y / N
Have surgery?	Y / N
Take Drugs?	Y / N

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

**3. Current Health Habits**

Did/do you...

- |   |       |                               |                       |
|---|-------|-------------------------------|-----------------------|
| Smoke?                                    | Y / N | Exercise Regularly?           | Y / N                 |
| Drink                                     | Y / N | Have trouble sleeping?        | Y / N                 |
| Diet (do you eat healthy foods?)          | Y / N | Have occupational stress?     | Y / N                 |
| Have you been in accidents?               | Y / N | Have physical stress?         | Y / N                 |
| Have you had surgery                      | Y / N | Have mental stress?           | Y / N                 |
| Drugs? (Prescriptive or Non-Prescriptive) | Y / N | Have hobbies/sports injuries? | Y / N                 |
| Have Teeth Problems?                      | Y / N | Sleeping posture              | Side – Back - Stomach |
| Have Eye Problems?                        | Y / N |                               |                       |
| Have Hearing Problems?                    | Y / N |                               |                       |

Height \_\_\_\_\_ Weight \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

**Current Health Condition**

Reason For Your Visit Today \_\_\_\_\_

Pain or Problem started on \_\_\_\_\_

Pains are:     Sharp         Dull         Constant     Intermittent

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is condition worse during certain times of the day? \_\_\_\_\_

Is this condition interfering with work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Routine? \_\_\_\_\_ Other? \_\_\_\_\_

Is this condition getting progressively worse? \_\_\_\_\_

Other Doctors seen for this condition \_\_\_\_\_

Any home remedies? \_\_\_\_\_

**Other symptoms:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Face Flushed           | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Feet Cold       |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Neck Stiff             | <input type="checkbox"/> Loss of Memory     | <input type="checkbox"/> Hands Cold      |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ring          | <input type="checkbox"/> Stomach Upset   |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever              | <input type="checkbox"/> Constipation    |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Numbness in Toes       | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Buzzing in Ear  |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Loss of Smell      |  |
| <input type="checkbox"/> Chest Pains       | <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Loss of Taste      |  |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Depression             | <input type="checkbox"/> Diarrhea           |  |

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to

**Please check all that apply**

- |   |   |
|---|---|
| <input type="checkbox"/> Feel better quickly    | <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier lifestyle                               |

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date