

Personal and Family Health History

Date _____ Referred By _____
 Name _____ Social Security # _____
 Address _____ Occupation _____
 City _____ State ____ Zip _____ Employer _____
 Home Phone _____ Work Phone: _____
 Cell Phone _____ Marital Status S M D W
 Date of Birth _____ Age _____ Spouse's Name _____
 Email: _____ Spouse's Occupation _____
 Emergency Contact: _____, Relationship _____, Phone _____

Do you have Health Insurance? Y N Insurance Company _____ Policy # _____
 Name of Primary Insured[⊗] spouse/parent _____ Birthdate: _____ SS# _____
 Spouse's Employer _____ Employer Address _____
 Do you have secondary insurance? Y / N If yes,
 Name of Ins. Company _____ Plan / Group # _____

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

Describe your symptoms: _____

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? _____ Daily Living Activities? _____

Is this condition getting progressively worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Other symptoms:

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

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