

Date _____

Your Health History

Name _____ Email: _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (H) _____ (W) _____ (C) _____ DoB _____ Age _____
 Referred by _____ Social Security # _____
 Email address: _____ Can we contact you via email: Y / N
 Occupation _____ Employer _____
 Marital Status S M D W Spouse Name _____ Number of Children/Ages _____
 Have you ever received Chiropractic Care? Yes No If yes, date of last visit: _____
 Do you wish to have us verify if your insurance assists with you treatment? Yes No
 If yes, Named of insured: _____ Insured DOB: _____ Insured SS# _____

About Your Health

The human body is designed to be healthy. Throughout life, events or injuries occur which damage your health expression by affecting your nervous systems ability to maintain health. This case history will uncover the damage, especially to your nervous system and spine, which can result in poor health. Please be as accurate as you can and be sure to include any traumas or accidents from your past regardless of how long ago they occurred or whether you think them insignificant. Following your exam, your chiropractor will outline a course care to begin to correct the Subluxations or misalignments in your spine that help you recover your inborn/innate health potential. Your body is meant to be healthy.

1. Please circle for each of the following:

Patient's Comments

If yes, provide a brief explanation

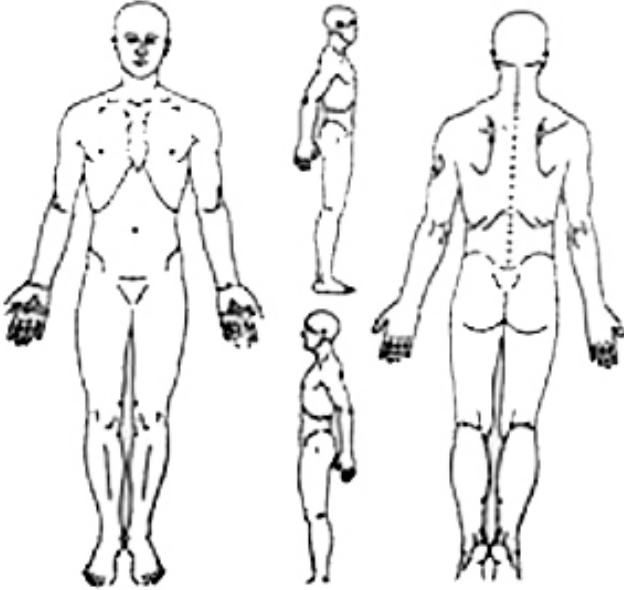
Current Health Habits:

Did/do you smoke or drink alcohol?	Y	N	How Often: _____
Diet, do you eat healthy foods?	Y	N	_____
Have you had any falls or trauma?	Y	N	What: _____ When: _____ Loss of Consciousness: Y/N
Car accidents?	Y	N	How many: _____ Dates: _____ Symptoms after accidents: _____
Have you had surgery (where)?	Y	N	(remark below)
Drugs, including Prescription?	Y	N	(list below)
Teeth/Jaw problems?	Y	N	_____
Eye or Hearing problems?	Y	N	_____
Exercise regularly?	Y	N	How often: _____
Emotional/Mental stress?	Y	N	_____
Hobbies/Sports injuries?	Y	N	_____
Do you sleep poorly?	Y	N	_____
Sleeping posture?			<input type="radio"/> side <input type="radio"/> stomach <input type="radio"/> back

2. Present Complaint/Reason for Seeking Care in this Office:

Chief Complaint(s) _____
 Pain or Problem started on: _____ Longer than **8 days** Y / N Pain is: **Severe Substantial Moderate Mild**
 Pains are: Sharp Dull/ Ache Constant Intermittent Other _____
 Pain right now: No Pain at All **0 1 2 3 4 5 6 7 8 9 10** Worst Pain Imaginable
 Pain at its worst: No Pain at All **0 1 2 3 4 5 6 7 8 9 10** Worst Pain Imaginable
 Have you had more than **4** previous episodes of this or a similar type pain: Y / N (regardless of severity)
 Does this pain shoot, radiate, or travel in your body? Y / N Where? _____
 Are you experiencing numbness or tingling in any area of your body? Where? _____
 What activities aggravate your condition/pain? _____
 What activities lessen your condition/pain? _____
 Is this condition worse during certain times of the day? _____
 Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
 Is this condition progressively getting worse? _____ Other Doctors seen for this condition _____
 Any home remedies? _____

Please mark you area(s) of pain on the figure below:



Please mark any of the following that you have now or have experienced:

- | | | |
|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in Hands or Arms | <input type="checkbox"/> Poor Posture |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Numbness in Hands or Arms | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pain in Legs or Feet | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Numbness in Legs or Feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Depression | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Lights Bother Eyes | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Pain between shoulders | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Sinus | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Menstrual Cramps |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Allergies | <input type="checkbox"/> Loss of Smell or Taste |

3. Are you currently under Medical Care? Y/N If yes, for what condition(s)? _____

What medications are you taking? _____ For how long? _____

Have you had surgery Y/N What? _____ When? _____

What side effects have you experienced from the drugs and surgery? _____

Females Only – Date last Menstrual Period began on _____ Are you possibly Pregnant? Y N

Is there a family History of:

	Heart Disease	Arthritis	Cancer	Diabetes	Thyroid Disorder
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"/>

Are you interested in: Temporary Pain Relief Total Correction of the Problem(s)

How would you rate your commitment to getting this problem corrected?

Low Commitment 1 2 3 4 5 6 7 8 9 10 High Commitment

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to do whatever is necessary in accordance with this state's statutes, to provide me with chiropractic care.

Patient or Guardian

Signature _____ Date _____