CONFIDENTIAL PERSONAL HISTORY FORM

PATIENT INFORMATION

Name ____

Address ______________________City ______________ State ___ Zip ___________

Home Phone (   ) __________________Work Phone (   ) ___________________

Cell Phone(   )______________________Email ______________________________

Age _______   Date of Birth____________________________________

Occupation __________________# Children ______ Spouse's Name ____________

Referred by ____

WHAT BRINGS YOU TO OUR OFFICE?

Describe your major complaint/reason for being here? ___________________________

____

Other complaints/Physical problems ____

How long have you had this condition? ___Have you had this condition in the past?____

What aggravates your condition? ____

Is this condition getting progressively worse? ( )Yes ( )No ( )Constant ( )Off/On

Is this condition interfering with your ( )Work ( )Sleep ( )Daily routine ( )Other

How long has it been since you felt well? ____

Have you had previous Chiropractic Care? _______________________________________

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain) ☐

"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns) ☐

Medical Doctor ☐

Dentist ☐

Other (please describe) ☐

INSURANCE INFORMATION

Is your condition due to an auto accident or work-related injury? (   )Yes (   ) No

If Yes, Date of Accident/Injury ____

Do you have Health Insurance? (   )Yes (   )No

Name of Company __________________Policy # ___________________________________

Are you covered by Medicare? (   )Yes (   )No

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MEDICAL HISTORY AND LIFESTYLE INFORMATION

Drugs you now take:

( )Nerve pills ( )Pain killers ( )Muscle relaxers ( )"Pep pills"( )Tranquilizers

( )Insulin ( )Birth control pills ( )Others ______________________________

Age of your mattress: __________ ( )Comfortable ( )Uncomfortable

Are you wearing: ( )Heel lifts ( )Sole lifts ( )Inner soles ( )Arch supports

Have you been in an auto accident?

( )Past year ( )Past 5 years ( )Past 10 years ( ) No Auto Accidents

Have you had any other personal injury or accident?
( )Past year ( )Past 5 years ( )Over 5 years ( )Never

If yes, please describe the incident: ___________________________________

____

____

Do you have a family history of any of the following:

Cancer	**( )Yes**	**( )No**
Diabetes	**( )Yes**	**( )No**
Hypertension	**( )Yes**	**( )No**

List surgical operations and the date of occurrence ______________________

____

____

Are you pregnant now? ( )Yes ( )No

Date of Last Period _____________________

Number of Pregnancies ________________

LIFESTYLE

What best describes your level of activity:
( )Sedentary ( )Light exercise ( )Active ( )Strenuous exercise

List any physical activities and frequency ___________________________

____

____

Do you have regular dental check-ups?	**( )Yes**	**( )No**
Do you wear a seatbelt while driving?	**( )Yes**	**( )No**

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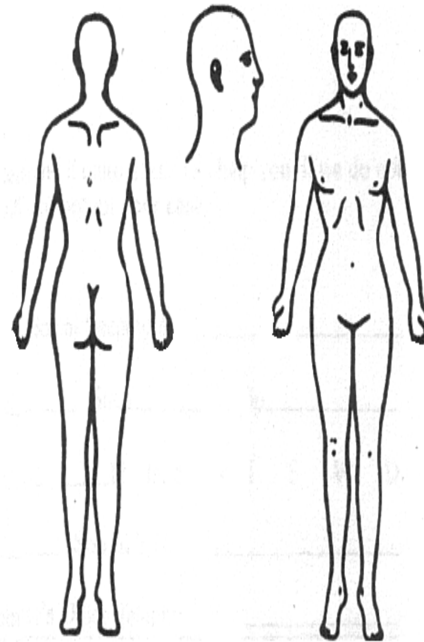
Please check if you now have or have ever experienced any of the conditions listed below:

SYMPTOM	Past	Present
Dizziness	( )	( )
Headaches	( )	( )
Stiff/Sore Neck	( )	( )
Swollen Glands	( )	( )
Loss of Smell	( )	( )
Sinus Problems	( )	( )
Nosebleeds	( )	( )
Blurred Vision	( )	( )
Blind Spots	( )	( )
Hearing Loss	( )	( )
Ringing in Ears	( )	( )
Loss of Balance	( )	( )
Neuritis	( )	( )
Twitching/Tremors	( )	( )
Heart Trouble	( )	( )
Diabetes	( )	( )
Arthritis	( )	( )
Asthma	( )	( )
Digestive Disorders	( )	( )
Nervousness	( )	( )
Shoulder Discomfort	( )	( )
Upper Back Pain	( )	( )
Chest/Rib Pain	( )	( )
Lower Back Pain	( )	( )
Knee Pain	( )	( )
Ankle/Feet Pain	( )	( )

Please mark your areas of pain on the figures below:



HIRSCHHORN FAMILY CHIROPRACTIC CENTER
505 OLD YORK RD; SUITE L 06; JENKINTOWN, PA 19046

STRESS ASSESSMENT

Do you consider your life stressful? ( )Yes ( )No

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work: ____ At home: ____ At play: ___

On a scale of 1-10, (1 being very poor and 10 being excellent) please describe your:

Eating habits: __ Exercise habits: __ Sleep: __ General health: __ Mind set: __

How do you grade your physical health?

Excellent □ Good □ Fair □ Poor □ Improving □ Worsening □

How do you grade your emotional/mental health?

Excellent □ Good □ Fair □ Poor □ Improving □ Worsening □

How do you manage or cope with these stresses? ________________________________

Have you had any of the following major changes in your life in the past year?

Moving your house or office	**( )Yes**	**( )No**
Death of a family member or friend	**( )Yes**	**( )No**
Change of job or career	**( )Yes**	**( )No**
Change of School	**( )Yes**	**( )No**

Do you feel rested when you awaken in the morning? ( )Yes ( )No

How many hours of sleep do you usually average per night? ______________

We believe that our patients must take personal responsibility to reclaim their health.

We are here to assist in that process through providing care, education, and support.

How long do you think it will take you to regain good health?

____

Your signature will verify that the information given is accurate:

Print Name: __________________________ Date: __________________________

Signature: ____

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