Health History

Name: _____DOB:_____Date: _____

Address: _____City: _____State: _____ Zip: _____

Email: _____Occupation: _____

Phone: _____Cell: _____Work Phone:_____

Married Single Partnered Dependent Children and ages: _____

Referred By: _____

Childhood History: *Circle all that apply*

Did you have any childhood illnesses?	**Yes**	**No**	_____
Did you have any serious falls or sport injuries as a child?	**Yes**	**No**	_____
Were you exposed to significant emotional or chemical stress as a child?	**Yes**	**No**	_____
Did you have any surgeries?	**Yes**	**No**	_____
Was there any prolonged use of medicine?	**Yes**	**No**	_____
Were you in any car accidents as a child or teenager?	**Yes**	**No**	_____
As a child, were you under regular chiropractic care?	**Yes**	**No**	

Please share any additional information:

_____

_____

Adult – (18 to present)

Do/did you smoke? **Yes** **No**

Do/did you drink alcohol? **Yes** **No**

Have you been in any accidents? **Yes** **No**

If yes, list here: _____

Have you had any surgery? **Yes** **No**

If yes, list here: _____

_____

Do/did you play adult sports? **Yes** **No**

On a scale of 1 – 10 describe your stress level:
(1 = none / 10 = extreme)

Occupational: _____ Personal:_____

Rate these following as Poor, Good, Excellent:

Diet: _____ What do you eat? _____

Exercise: _____ When and what? _____

Sleep: _____ Hours per day? _____

General Health: _____

Please list any medications and why: _____

_____

_____

Addressing issues that may have brought you to our office

If you have no symptoms or complaints, and are here for wellness services, please check here: _____
and then skip to Your Health History. Otherwise please briefly explain what brought you to our office today:

_____

_____

Does this interfere with: ___Work ___Sleep ___Walking ___Hobbies ___Leisure ___Other

Have you seen anyone else for this issue? ____yes _____no If yes, who? _____

_____

Please check (✓) all symptoms you have had in the last 3 months:

☐ Headaches	☐ High blood pressure	☐ Sinus congestion	☐ Neck pain/stiffness
☐ Pins and needles in arms	☐ Shoulder pain	☐ Upper/mid back pain	☐ Low back pain
☐ Dizziness	☐ Chest pain	☐ Ringing in ears	☐ TMJ pain
☐ Numbness/pain in fingers	☐ Numbness in toes	☐ Knee pain	☐ Elbow/wrist pain
☐ Anxiety	☐ Depression	☐ Ankle pain	☐ Foot pain
☐ Sleeping problems	☐ Sleep apnea/snoring	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Heartburn	☐ Hot Flashes
☐ Heart palpitations	☐ Loss of balance	☐ Urinary Problem	☐ Heartburn
☐ Mood Swings	☐ Menstrual Problems	☐ Other _____	

Your Health History:

Please circle any of the following health problems that you have or have had in the past:

thyroid, asthma, acid reflux or other digestive problems, high blood pressure, heart, stroke or circulatory problems,

dizziness, diabetes, hypoglycemia, arthritis, osteoporosis, prostate, PMS, medical implants, pacemaker, metal screws in joints,

cancer(explain)_____ Other conditions_____

Family Health Profile:

At our office we are not only interested in your health and wellbeing but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: _____
Spouse: _____
Mother: _____
Father: _____
Brother(s): _____
Sister (s): _____

Do you:

Drink Coffee or Caffeinated Tea ? Yes No

Drink Soda? Yes No (Diet or Regular)

What do you do for stress relief?

_____

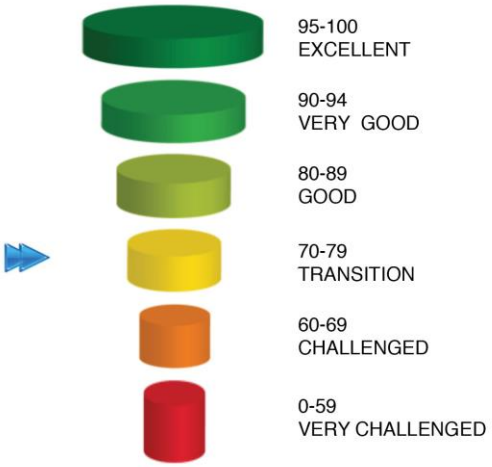
_____

How many times a week do you exercise? _____

Are there any other health habits that you could share with us? _____

_____

Please mark an "X" where you believe your health is and an "O" where you would like to be.



How long do you think it will take to get to where your circled? _____

What things might you need to change to reach your goal?

a. _____

b. _____

c. _____

d. _____

About Chiropractic

Chiropractic is different from the medical care you might be used to. To help you understand what to expect, we ask you read the brief explanation below and acknowledge that with your signature.

There are **4 basic principles** of chiropractic:

1. The body is self-healing. If you get a cut, it will heal. If a corpse gets a cut, it won't.
2. The brain and its nerve system are what run, regulate and heal your body.
3. Stress can cause interference & disturbance to one or more of your nerve circuits.
4. Chiropractic adjustments gently & systematically reverse this process.

Stress: most health problems result from some combination of physical, chemical or emotional/mental stress that the body is unable to handle properly.

Pain and other symptoms are your body's way of alerting you to a problem, like the "**check engine light**" on a car. The purpose of most drugs is to suppress symptoms, whether it is pain or inflammation.

The chiropractic adjustment does not suppress your body, but goes deeper and wakes up its ability to heal. As this process unfolds, your pain or other symptoms will naturally start to subside as your body gets stronger.

This principle always works. However, the speed of the body's response to this varies widely and depends on countless stresses, lifestyle choices and injury severity that I as a chiropractor have no control over. So this healing process is definitely a **partnership**.

The purpose of this first visit is to evaluate both your injury and any underlying stresses that may have contributed to it**,** with both computerized nerve scans and a chiropractic physical exam.

In Conclusion: Chiropractic is a drugless approach to healthcare that uses the body's natural healing energy to address the issues that bring people in. We focus on rebuilding your natural reserves while coaching you to make wise and healthy decisions. Most of our clients learn that chiropractic can be used to get well and stay well for a lifetime. Welcome to the way of the future: less drugs and more control over your own health.

I have read the above statements and fully understand that the purpose of care in this clinic is not to cure a specific disease, but revive the body's own ability to heal.
I also understand & agree that payment is always either prepaid or due at the time of the visit, unless other arrangements have been made, and that I am responsible for all bills incurred in this office.

(printed name)	(signature)	(date)

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____
have read and fully understand the above statements and hereby grant permission for my child to receive chiropractic care.

(signature)	(date)