Personal Health History

Name _____ Date of Birth _____ (Age _____)

Address _____ Marital Status S M D W

City _____ State _____ Zip _____ Emergency Contact _____

Phone: (H) _____ (W) _____ EC Number_____

Cell: _____ Provider: _____ Relation to EC _____

E-mail _____ Person who referred you _____

Occupation _____

Please Circle All That Apply

1. Birth/Infancy		***Comments***	***2. Growth and Development***		***Comments***
Long Delivery?	Y	_____	Fall out of bed?	Y	_____
Difficult Delivery?	Y	_____	Bang your head?	Y	_____
Forceps?	Y	_____	Childhood sickness?	Y	_____
Caesarian?	Y	_____	Have any Accidents?	Y	_____
Breach?	Y	_____	Have Surgery?	Y	_____
Home birth?	Y	_____	Medications/Vaccines?	Y	_____
Meds during delivery?	Y	_____	Fall learning to walk?	Y	_____
Induced Labor?	Y	_____	Bullied by siblings?	Y	_____
Breastfed?	Y	_____	Physical/Sexual abuse?	Y	_____
Vaccines?	Y	_____	Other traumas?	Y	_____

3. Current Health Habits		***Comments***			***Comments***
Did/do you smoke?	Y	_____	Have sleeping problems?	Y	_____
Did/do you drink alcohol?	Y	_____	Have occupational stress?	Y	_____
Do you eat sugary foods?	Y	_____	Have physical stress?	Y	_____
OTC or Prescription Drugs?	Y	_____	Have mental stress?	Y	_____
Illegal/Recreational Drugs?	Y	_____	Have hobbies?	Y	_____
Exercise regularly?	Y	_____	Play sports?	Y	_____

Sleeping position: R Side L Side Back Stomach

Hours of sleep: _____ Quality: Good Fair Poor

Would you answer "yes" to any of these for your spouse or children? Y N

Personal Health History

Current Health Condition

Present Complaint or Crisis? If no current crisis, what is the main reason for your visit today?

_____

Pain or Problem started on _____ What caused it? _____

Complaint is: ❒ Better ❒ Worse ❒ Same ❒ Comes and goes Does it travel? _____

What makes it worse?		What makes it better?	
☐Driving	☐Breathing	☐Chiropractic	☐Heat
☐Walking	☐Coughing	☐Rest	☐Stretching
☐Sitting	☐Sleeping	☐Lying Down	☐Massage
☐Bending	☐Working	☐Sitting	☐Medication
☐Standing	☐Exercising	☐Standing	☐Ice/Cold
☐Bowel Movement	☐Other _____	☐Walking	☐Other _____

Rate your pain TODAY: 1☐ (best) 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ (worst)

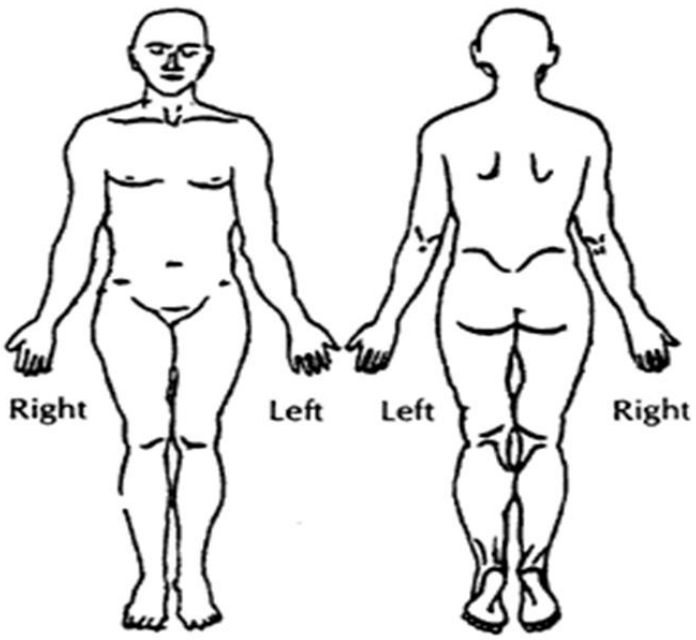
Rate your AVERAGE pain: 1☐ (best) 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐ (worst)

Is it worse during certain times of the day? _____ Better? _____

Is this condition interfering with: Work ☐ Sleep ☐ Daily Routine ☐ Other Activities ☐

Other doctors seen? _____ Imaging? _____

Any home remedies? _____



PAIN DIAGRAM

Please mark the location(s) of your pain using the following symbols:

N = numbness/tingling
^ = sharp/stabbing
B = burning
S = shooting/travelling
A = aching
O = other (describe)
T = tightness

Personal Health History

Other symptoms:

❒ Headaches	❒ Face Flushed	❒ Light Bothers Eyes	❒ Feet Cold
❒ Neck Pain	❒ Neck Stiff	❒ Loss of Memory	❒ Hands Cold
❒ Sleeping Problems	❒ Pins & Needles in Legs	❒ Ears Ringing	❒ Stomach Upset
❒ Back Pain	❒ Pins & Needles in Arms	❒ Fever	❒ Constipation
❒ Nervousness	❒ Numbness in Fingers	❒ Fainting	❒ Loss of Balance
❒ Tension	❒ Numbness in Toes	❒ Cold Sweats	❒ Buzzing in Ear
❒ Irritability	❒ Shortness of Breath	❒ Loss of Smell	
❒ Chest Pains	❒ Fatigue	❒ Loss of Taste	
❒ Dizziness	❒ Depression	❒ Diarrhea	

Have you had any serious accidents or falls? Y N _____

_____

What medications or supplements are you taking? _____

_____

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

_____

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

_____

Previous chiropractic care? Y N Office: _____

Reason for previous care _____Approximate date of last visit? _____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Obesity	Other
Father's Side	❒	❒	❒	❒	❒	❒ _____
Mother's Side	❒	❒	❒	❒	❒	❒ _____

Your oldest grandparent lived to the age of _____. ❒ Living ❒ Deceased

TERMS OF CARE

Quintessential CHIROPRACTIC

You deserve to be healthy. When you were conceived, you were given the blue-prints, intelligence, and systems to live an active, healthy, long life. Unfortunately, the natural expression of your health can be interfered with. Through your involvement in chiropractic care we will work to remove these interferences, allowing you to heal more quickly and live the quality lifestyle you deserve.

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be able to attain it. This will prevent any confusion or disappointment.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of a subluxation. Our chiropractic method of correction is by specific adjustments of the spine and extremities.

Health: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

Subluxation: A misalignment of one or more joints which alters nerve function and decreases the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Our only objective is to eliminate interference to the expression of your body's innate ability to maintain health. Our only method is specific adjusting to correct subluxations.

Health is affected by your nervous system, but it is also affected by your environment, the foods you eat, and your lifestyle activities and habits. Chiropractic care is an important addition to a healthier lifestyle but requires TIME to allow your body to heal.

We ask that you commit to 12 visits in order to maximize your response to the care received in this office

I, _____ have read and fully understand the above statements.
(print name)

I therefore accept chiropractic care on this basis.

_____ _____
Patient Signature Date