Werner Family Chiropractic

Personal and Family Health History

Name _____

DOB _____

Current Health Condition

Present Complaint or Crisis:

Is there a certain event/activity that onset this problem/pain?

How would you describe the problem/pain?

[ ] Sharp [ ] Stabbing [ ] Dull Ache [ ] Radiating to other body areas
[ ] Constant [ ] Intermittent

How severe is the problem/pain on a scale of 1-10? _____

How long has the problem/pain been present?

_____ Days _____ Weeks _____ Months

Is the condition worse at certain times of the day? _____

Is the condition interferring with daily routine? _____

Work? _____ Sleep? _____ Other? _____

What makes the problem/pain better?

What makes the problem/pain worse?

Any other symptoms present?

[ ] Headaches [ ] Numbness [ ] Dizziness [ ] Shortness of Breath [ ] Sensitivty to Light
[ ] Ears Ringing [ ] Fever [ ] Fainting [ ] Cold Sweats [ ] Diarrhea/Constipation
[ ] Loss of Bladder/Bowel Control [ ] Cold Extremities [ ] Upset Stomach
[ ] Loss of Balance

Past Personal History

1. Was <u>your</u> birth a difficult delivery?	Yes	No
a. Forceps?	Yes	No
b. C-Section?	Yes	No
c. Home Delivery?	Yes	No
2. Did you ever once…		
a. Learn to care for your spine?	Yes	No
b. Fall out of bed?	Yes	No
c. Bang your head	Yes	No
d. Fall down stairs?	Yes	No
e. Pulled by your arm?	Yes	No

(Continued Past Personal History)

f. Fall while learning to walk? Yes No
g. Chair pulled out from underneath you? Yes No

3. Have you had surgery? Yes No

If yes, what surgeries? _____

_____

When? _____

Side effects from the drugs and/or surgery? Yes No

If yes, what side effects? _____

_____

Family History

	Heart Disease	Arthritis	Cancer	Diabetes
Father's Side	[ ]	[ ]	[ ]	[ ]
Mother's Side	[ ]	[ ]	[ ]	[ ]

Other? _____

Your oldest grandparent on the record lived to the age of? _____

[ ] Still living [ ] Deceased

Social History

Did you/Do you…

a. Use Tobacco? Yes No
Type _____
Packs per day _____
Quit _____
b. Consume Alcohol? Yes No
Drinks per week _____
c. Consume Caffiene? Yes No
(tea, coffee, soda, energy drinks/pills)
Servings per day _____

d. Eat healthy foods? Yes No
e. Drink water daily? Yes No
f. Exercise? Yes No
How many times a week? _____
Type of exercise _____

g. Sleeping posture- [ ] Side [ ] Back [ ] Stomach

Review of Systems

Do you currently have any of the following?

General
[ ] Fatigue
[ ] Weight Gain
[ ] Weight Loss

Skin
[ ] Nail Changes
[ ] New Lesions
[ ] Rash
[ ] Skin Color Changes

HEENT
[ ] Double Vision
[ ] Eye Pain
[ ] Eye Redness
[ ] Decreased Hearing
[ ] Earache
[ ] Ear Ringing
[ ] Nose Bleeds
[ ] Dry Mouth
[ ] Oral Ulcers
[ ] Sore Throat

Respiratory
[ ] Chronic Cough
[ ] Difficulty Breathing
[ ] Coughing Up Blood
[ ] Sputum Production
[ ] Wheezing

Cardiovascular
[ ] Chest Pain
[ ] Leg Pains w/ Walking
[ ] Leg Swelling
[ ] High Blood Pressure
[ ] Palpitations

Hematology
[ ] Easy Bruising
[ ] Prolonged Bleeding
[ ] Enlarged Lymph Nodes

Gastrointestinal
[ ] Abdominal Pain
[ ] Change in Bowel Habits
[ ] Constipation
[ ] Diarrhea
[ ] Nausea
[ ] Vomitting
[ ] Rectal Bleeding
[ ] Trouble Swallowing

Genitourinary
[ ] Increased Frequency
[ ] Loss of Bladder Control
[ ] Blood in Urine
[ ] Nighttime Urination

Endocrine
[ ] Appetite Changes
[ ] Cold Intolerance
[ ] Increased Thirst
[ ] Hair Changes

Neurological
[ ] Dizziness/Vertigo
[ ] Headaches
[ ] Numbness/Tingling
[ ] Passing Out
[ ] Seizures
[ ] Tremors
[ ] Spasms

Musculoskeletal
[ ] Decreased Range of Motion
[ ] Joint Pain
[ ] Joint Redness/Swelling
[ ] Joint Stiffness
[ ] Muscle Weakness
[ ] Muscle Aches/Pain
[ ] Osteoarthritis
[ ] Osteoporosis

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. Active Life Plans are designed to get you feeling better quickly and to help you and your family be as healthy as possible.

Printed Patient Name _____

Patient/Guardian Signature _____

Date _____