PERSONAL AND FAMILY HEALTH HISTORY

Name ______________________________________
Date ______________________________________
Address ____________________________________
City ___________________ State ____ Zip ________
Phone: (H) ______________ (W) _______________
E-mail _____________________________________
Date of Birth ______________ (Age ______)
Social Security # _____________________________

Referred By ________________________________
Occupation _________________________________
Employer ___________________________________
Employer Phone #:___________________________
Employer Address:___________________________
____
Marital Status S M D W
Spouse's Name/Occupation___________________
Primary Physician's Name____________________

Number of Children and Ages **Previous Chiropractic Care?**

Name ___________________________ Age _____ Yes___ No___ Reason ____________________________
Name ___________________________ Age _____ Yes___ No___ Reason ____________________________
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Name ___________________________ Age _____ Yes___ No___ Reason ____________________________

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Circle all that Apply	**Patient**	**Spouse**	**Child#1**	**Child#2**	**Child #3**	**Chiropractor's Comments**
Current Health Habits						
Did/do you...						
Smoke?	Y	Y	Y	Y	Y	________________
Drink?	Y	Y	Y	Y	Y	________________
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	________________
Have you been in accidents?	Y	Y	Y	Y	Y	________________
Have you had surgery and organs replaced/removed?	Y	Y	Y	Y	Y	________________
Drugs? (Prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	________________
Have Teeth Problems?	Y	Y	Y	Y	Y	________________
Have Eye Problems?	Y	Y	Y	Y	Y	________________
Have Hearing Problems?	Y	Y	Y	Y	Y	________________
Exercise regularly?	Y	Y	Y	Y	Y	________________
Have sleeping problems? (nightmares)?	Y	Y	Y	Y	Y	________________
Have occupational stress?	Y	Y	Y	Y	Y	________________
Have physical stress?	Y	Y	Y	Y	Y	________________
Have mental stress?	Y	Y	Y	Y	Y	________________
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	________________

Current Health Condition

Present Complaint (be brief) Reason For Your Visit Today
Major ____
Pain or Problem started on____
Pains are: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent
What activities aggravate your condition/pain? _____________________________

What activities lessen your condition/pain? ____
Is condition worse during certain times of the day? ____________________________________
Is this condition interfering with work? ______ Sleep? ______ Routine? ______ Other? _______
Is this condition getting progressively worse? ____
Other Doctors seen for this condition ____
Any home remedies? ____

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 Ring	❐ 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 been under drug and medical care? ____
What medications are you taking? ____
How Long? ________________ Have you had surgery? _______________ What? ________ When?__________
What side effects have you experienced from the drugs and surgery? ___________________________________

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _______________
Father's Side	❐	❐	❐	❐	❐
Mother's Side	❐	❐	❐	❐	❐

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. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to

Please check all that apply

❐ Feel better quickly
❐ Have a healthier spine
❐ Have a healthier body by keeping my nerve system healthy
❐ Live a healthier lifestyle

_______________________________________ Signature

__________________ Date