Your Health History

Name: ______________________________ Age: ________ Male_____ Female _____ Date: ______________

Address: ____________________________ City: _______________ State: __________ Zip: __________

Home Phone: (   ) ______________ Cell Phone: (   ) ______________ Work Phone: (   ) ______________

Birth Date: ______________ Single_____ Married_____ Divorced_____ Widowed_____ No. of children: _____

Occupation/Employer'sName______________________________Spouse's/Occupation/Employer______________________

Who may we thank for referring you to our office? ____

Reason for consulting our office? ____

***This form is important** because we are a full spectrum chiropractic wellness center. We focus on your ability to be healthy and function normally. Our goal is to address the issues that first brought you into the office. As our relationship builds together, our goal is to offer you the continued opportunity for increased health potential and wellness services. Everyday we experience stress that is physical, chemical and emotional in nature. If our bodies are unable to take care of stress at the time it occurs, the effects of the stress will accumulate. Most of the effect of repeated or numerous stressors are gradual, not even noticed until they become serious. The following questions will start to give us a profile of specific challenges or series of events you have faced in your lifetime, allowing us to better understand the experiences that may have changed your health.*

***Research** is showing that many of the health challenges that are noticed later in life have their origins starting at birth or during the developmental years.*

Your childhood (0-17years):

	Yes	No	??		Yes	No	??
Have any serious falls as a child?	__	__	__	Were you vaccinated?	__	__	__
Have any serious hits to your head?	__	__	__	Any prolonged or repeated use of medications such as antibiotics or an inhaler?	__	__	__
Have any surgery?	__	__	__	Play any youth sports?	__	__	__
Any falls/ jumps from heights greater than 3 feet? (tree, crib, etc.)	__	__	__	Any childhood illnesses?	__	__	__
In any car accidents as a child?	__	__	__	Any use of drugs?	__	__	__
Any other physical or emotional traumas?	__	__	__				

Were you under regular Chiropractic care as a child? __________

Comments or explanations of the above: ____

____

____

Adulthood (18- present)

	Yes	No		Yes	No
In any car accidents?	__	__	In any other accidents?	__	__
Have any surgery?	__	__	Do / did you play any adult sports?	__	__
Do / did you smoke?	__	__	Do / did you play any extreme sports?	__	__
Do / did you drink alcohol	__				

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

On a 1 – 10 scale, describe your occupational stress level: _____________

On a scale of Excellent, Good, or Poor, describe your:

Diet__________________ Exercise__________________ Sleep________________ General Health_________________

Do you hydrate yourself daily with water? _________________ About how many glasses of water? ____________________

If you are here for wellness services and have no current complaints or symptoms, please check here ______ and skip the next section and resume with the symptom list below. Otherwise, please briefly describe the main area of complaint, including the impact it has had on your life.

____

____

If you are experiencing pain, is it…

__ Sharp __ Dull __ Comes and goes __ Travels __ Constant

Since the problem started, it is…. __ Getting Better __ Getting Worse __ About the Same

What makes it worse? ____

It interferes with: __ Work __ Sleep __ Walking __ Sitting __ Hobbies __ Leisure __ N/A

Other Doctors seen for this problem (please list):

Chiropractor: ____

Medical Doctor: ____

Other: ____

Please check all symptoms you have ever had, even if they do not seem related to your current problem.

__Neck Pain or stiffness	__Insomnia or sleeping problems	__Fever	__Cold Sweats
__Pins & Needles in Arms	__Constipation	__Cold Hands or feet	__Loss of Smell
__Numbness in Hands or Fingers	__Diarrhea	__Problem urinating	__Loss of Taste
__Back Pain or stiffness	__Stomach Upset	__Muscle Cramps	__Lights bother eyes
__Pins & Needles in Legs	__Nervousness	__Buzzing in Ears	__Hot flashes
__Numbness in Feet or Toes	__Mood Swings	__Fainting	__Heartburn
__Headaches	__Irritability	__Loss of Balance	__Ulcers
__Migraines	__Tension	__Ringing in Ears	__Menstrual Pain
__Tension	__Depression	__Dizziness	__Menstrual Irregularity

Do you experience fatigue? Yes or No If yes, on a 1 – 10 scale, please answer to what level.________

Please list any medications you are taking: ____

____

Family Health History

At our office we are very interested in your health and wellness, and also the health and wellness of your family and loved ones. Please mention below any health conditions or concerns you may have about you:

Children ____

Spouse ____

Mother ____

Father ____

Brothers ____

Sisters ____

Others ____

Have you ever:

Purchased bottled water? Yes or No

Belonged to a health club? Yes or No

Taken vitamins or supplements? Yes or No

What goals would you like to achieve with the help of our office? ____________________________

____

The statements made on this form are accurate to the best of my knowledge and I agree to allow this office to examine me for further evaluation.

Sign: ____________________________ ***Date:*** ________________