

## Personal and Family Health History

Name \_\_\_\_\_  
 Date \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 E-mail \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ (Age \_\_\_\_\_)

Referred By \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Marital Status    S            M            D            W  
 Spouse's Name \_\_\_\_\_  
 Spouse's Occupation \_\_\_\_\_

### Number of Children and Ages

Name \_\_\_\_\_ Age \_\_\_\_\_ Yes \_\_\_ No \_\_\_ Reason \_\_\_\_\_  
 Name \_\_\_\_\_ Age \_\_\_\_\_ Yes \_\_\_ No \_\_\_ Reason \_\_\_\_\_  
 Name \_\_\_\_\_ Age \_\_\_\_\_ Yes \_\_\_ No \_\_\_ Reason \_\_\_\_\_  
 Name \_\_\_\_\_ Age \_\_\_\_\_ Yes \_\_\_ No \_\_\_ Reason \_\_\_\_\_

### Previous Chiropractic Care?

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blueprints, 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.

	<i>Patient</i>	<i>Spouse</i>	<i>Child#1</i>	<i>Child#2</i>	<i>Child #3</i>	<i>Chiropractor's Comments</i>
<b>Circle all that Apply</b>						
<b>1. Was Your Birth Traumatic?</b>						
Long Delivery?	Y	Y	Y	Y	Y	_____
Difficult Delivery?	Y	Y	Y	Y	Y	_____
Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach/cephalic?	Y	Y	Y	Y	Y	_____
Home birth?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery	Y	Y	Y	Y	Y	_____
Induced Labor?	Y	Y	Y	Y	Y	_____
<b>2. Growth and Development</b>						
Did you ever once...						
Learn to care for your spine?	Y	Y	Y	Y	Y	_____
Fall out of bed?	Y	Y	Y	Y	Y	_____
Bang your head?	Y	Y	Y	Y	Y	_____
Breastfeed?	Y	Y	Y	Y	Y	_____
Childhood sickness?	Y	Y	Y	Y	Y	_____
Have any Accidents?	Y	Y	Y	Y	Y	_____
Have Surgery?	Y	Y	Y	Y	Y	_____
Take Drugs?	Y	Y	Y	Y	Y	_____
Fall while learning to walk?	Y	Y	Y	Y	Y	_____
Bullied by your siblings?	Y	Y	Y	Y	Y	_____
Child abuse	Y	Y	Y	Y	Y	_____
Spanking?	Y	Y	Y	Y	Y	_____
Pulled ear/chin	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____
Chair pulled out when sitting?	Y	Y	Y	Y	Y	_____
Fall down the stairs?	Y	Y	Y	Y	Y	_____
Pulled by your arm?	Y	Y	Y	Y	Y	_____
Experience other traumas?	Y	Y	Y	Y	Y	_____
<b>3. Current Health Habits</b>						
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	_____
Sleeping posture – side–stomach–back	_____	_____	_____	_____	_____	_____

**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:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Face Flushed           | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Feet Cold       |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Neck Stiff             | <input type="checkbox"/> Loss of Memory     | <input type="checkbox"/> Hands Cold      |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Ears Ring          | <input type="checkbox"/> Stomach Upset   |
| <input type="checkbox"/> Back Pain         | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Fever              | <input type="checkbox"/> Constipation    |
| <input type="checkbox"/> Nervousness       | <input type="checkbox"/> Numbness in Fingers    | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Tension           | <input type="checkbox"/> Numbness in Toes       | <input type="checkbox"/> Cold Sweats        | <input type="checkbox"/> Buzzing in Ear  |
| <input type="checkbox"/> Irritability      | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Loss of Smell      |  |
| <input type="checkbox"/> Chest Pains       | <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Loss of Taste      |  |
| <input type="checkbox"/> Dizziness         | <input type="checkbox"/> Depression             | <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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Signature

Date