

**Personal and Family Health History**

File # \_\_\_\_\_

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**

**Previous Chiropractic Care?**

Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____
Name _____	Age _____	Yes ___	No ___	Reason _____

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 examination and through your involvement in chiropractic care, we will work to remove these interferences and keep them out of your life, so that you can heal quickly and live the quality lifestyle you deserve.

	<b>Patient</b>	<b>Spouse</b>	<b>Child#1</b>	<b>Child#2</b>	<b>Child #3</b>	<b>Chiropractor's Comments</b>
<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 or Crisis? If no current crisis, what is the 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?  
 \_\_\_\_\_

**Family History:**

	Heart Disease	Arthritis	
	Cancer	Diabetes	
	Other _____		
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Your oldest grandparent on record lived to the age of \_\_\_\_\_.**

- Still living             Deceased

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. Please review the Active Life Plan Explanations prior to your Chiropractic Report 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 and nervous system  
 Live a healthier lifestyle

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date