POJERO FAMILY
CHIROPRACTIC

153 Main Street, #2, Sayville, NY 11782 | (631) 244-0300
info@pojerofamilychiropractic.com | www.pojerofamilychiropractic.com

PERSONAL HEALTH HISTORY

Name: _____ Date: _____Date of Birth: _____

Address: _____ City/State/Zip: _____

Email: _____ Home Phone #: _____ Cell Phone #: _____

Marital Status: _____ Spouse's Name: _____ Spouse's Age: _____

Children's Names & Ages: _____

Occupation: _____ Name of Employer: _____

Hobbies: _____

Reasons For Consulting Our Office: _____

Referred By: _____

Previous Chiropractic Care? ☐ Yes ☐ No If Yes, With Whom? _____

How Long Was Care Received? _____ When was Your Last Visit? _____

Accidents:

What accidents have you had *(ex. bicycle, car motorcycle, sports, slips/falls)* at work or at home? Please include dates:

_____

Were you ever knocked unconscious? ☐ Yes ☐ No

What fractures or broken bones have you had? *(Include dates)* _____

_____

Surgery:

What major surgery have you had? *(Include dates)* _____

_____

_____

What minor surgery have you had? *(ex. Tonsillectomy, Appendectomy, Wart/Cyst Removal, Dental Extraction)*

_____

_____

Medication:

Present Prescription Drugs: _____

Past Prescription Drugs: _____

Over-the-Counter Drugs *(Aspirin, Cold Tablets, Cough Syrup etc.):* _____

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PERSONAL HEALTH HISTORY (CONTINUED)

Name: _____ Date: _____Date of Birth: _____

Therapy:

Are you presently under any therapeutic care? ☐ Yes ☐ No If Yes, What Type? _____

What therapeutic care have you been under in the past? *(Radio, chemo, physio, electro, etc. Include dates)*

_____

_____

Birth Record:

Type of Birth: *(Vaginal, Cesarean, etc.)* _____

Any complications during your mother's pregnancy, or during your birth? _____

_____

Any complications after your birth? _____

_____

Current Health:

How would you describe your current health? _____

How would you describe your family's health? _____

Describe Your Vision: _____ Describe Your Hearing: _____ Describe Your Coordination: _____

Do you use any of the following? ☐ Tobacco ☐ Alcohol ☐ Coffee/Tea ☐ Cola ☐ Milk

Do you purchase any of the following?

☐ Bottled Drinking Water ☐ Vitamins ☐ Coffee/Tea ☐ Cola ☐ Milk ☐ Health Food Products *(organic products, etc.)*

Level of stress in your life: ☐ Mild ☐ Moderate ☐ Extreme ☐ Scale 1-10: _____

Financial Information:

Who is responsible for this account? _____ Relationship: _____

Date of Birth:_____

Employer: _____

What method of payment will you be using? ☐ Insurance ☐ Cash ☐ Check ☐ Other: _____

Insurance Company: _____ Policy/ID#: _____

Address: _____ Phone #:_____

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PERSONAL HEALTH HISTORY (CONTINUED)

Name: _____ Date: _____Date of Birth: _____

Please check any of the following that give you difficulty or you have had recently:

- ☐ Headaches
- ☐ Fainting
- ☐ Shortness of breathe
- ☐ Numbness in legs/feet
- ☐ Shooting head pains
- ☐ Loss of balance
- ☐ Mid-back pain
- ☐ Constipation
- ☐ Sinus trouble
- ☐ Ringing in the ears
- ☐ Heart attack
- ☐ Kidney troubles
- ☐ Loss of smell
- ☐ Blurred vision
- ☐ Low blood pressure
- ☐ Menstrual cramp/pain
- ☐ Allergies
- ☐ Lights bother eyes
- ☐ High blood pressure
- ☐ Menstrual irregularity
- ☐ Hay fever
- ☐ Neck pain
- ☐ Anemia
- ☐ Diabetes
- ☐ Asthma
- ☐ Muscle spasms in neck
- ☐ Stomach trouble
- ☐ Sleeping problems
- ☐ Loss of taste
- ☐ Grinding in neck
- ☐ Nerves/Nervousness
- ☐ Painful joints
- ☐ Inflammation of throat
- ☐ Shoulder/arm tight
- ☐ Inner Tension
- ☐ Swollen Joints
- ☐ Thyroid trouble
- ☐ Shoulder/arm pain
- ☐ Irritability
- ☐ Pins & needles in leg
- ☐ Facial twitch
- ☐ Pins & needles in arm
- ☐ Gall bladder trouble
- ☐ Swollen ankles
- ☐ Loss of Memory
- ☐ Pins & needles in hands
- ☐ Indigestion
- ☐ Cold feet
- ☐ Loss of Memory
- ☐ Pins & needles in hands
- ☐ Indigestion
- ☐ Cold feet
- ☐ Fatigue
- ☐ Cold hands
- ☐ Intestinal Gas
- ☐ Pain in legs/feet
- ☐ Depression
- ☐ Numbness in arm/hand
- ☐ Low back pain
- ☐ Hip pain
- ☐ Dizziness
- ☐ Tonsillitis
- ☐ Sciatic pain
- ☐ Facial pain
- ☐ Spinal curvature
- ☐ Prostate trouble
- ☐ Stroke
- ☐ Jaw pain (TMJ)
- ☐ Chest pain
- ☐ Bed wetting
- ☐ Arthritis
- ☐ Ulcers
- ☐ Earache
- ☐ Cancer
- ☐ Seizures
- ☐ Hernia