

PERSONAL HEALTH HISTORY

Date: _____

Name: _____ Email: _____

Address: _____ City/State/Zip: _____

Date of Birth: _____ SS#: _____

Home Phone #: _____ Cell Phone #: _____

Name of Employer: _____ Occupation: _____

Marital Status: _____

Spouses Name : _____ Spouses Age: _____

Children's Names and Ages: _____

Hobbies: _____

Referred By: _____

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

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

Reasons For Consulting Our Office: _____

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.):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

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

Do you purchase any of the following?

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

Financial Information:

Who is responsible for this account? _____ Relationship: _____

Date of Birth: _____ SS#: _____ Employer: _____

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

Insurance Company: _____ Policy/ID#: _____

Address: _____ Phone #: _____

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

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