Health History

Name: ____DOB:_______________Date: ___________

Address: __________________________________City: ______________State: _________ Zip: __________

Email: ____Occupation: _____________________________

Phone: _____________________Cell: ______________________Work Phone:_______________________

Married Single Divorced Widowed Kids: ____

Referred By: ____

Childhood History: *Circle all that apply*

Did you have any childhood illnesses?	**Yes**	**No**
Did you have any serious falls as a child?	**Yes**	**No**
Did you play youth sports?	**Yes**	**No**
Did you take Medications?	**Yes**	**No**
Did you have surgery?	**Yes**	**No**
Have you fallen / jumped from a height over three feet?	**Yes**	**No**
Were you in any car accidents as a child?	**Yes**	**No**
Was there any prolonged use of medicine such as antibiotics or an inhaler?	**Yes**	**No**
Did you suffer any other traumas (physical or emotional)	**Yes**	**No**
As a child, were you under regular chiropractic care?	**Yes**	**No**

Please share any additional information:

____

____

Adult – (18 to present)

Do/did you smoke? **Yes** **No**

Do/did you drink alcohol? **Yes** **No**

Have you been in any accidents? **Yes** **No**

Have you had any surgery? **Yes** **No**

If yes, list here: ____________________

____

Do/did you play adult sports? **Yes** **No**

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

Occupational: _____ Personal:_____

Rate these following as Poor, Good, Excellent:

Diet: ________ **What do you eat?** _______________________

Exercise: _______ **When and what?** _____________________

Sleep: _______ **Hours per day?** _________________________

General Health: ____________

Please list any medications: ___________________________

____

____

Addressing issues that may have brought you to our office

If you have no symptoms or complaints, and are here for wellness services, please check here: ______
and then skip to Family Health Profile. Otherwise please briefly explain what brought you to our office today:

____

____

Does this interfere with: ___Work ___Sleep ___Walking ___Hobbies ___Leisure ___Other

Have you seen anyone else for this issue? ____yes _____no If yes, who? ______________________

____

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

Headaches	Pins and needles in legs	Fainting	Neck pain
Pins and needles in arms	Loss of smell	Back Pain	Loss of balance
Dizziness	Buzzing in ears	Ringing in ears	Nervousness
Numbness in fingers	Numbness in toes	Loss of taste	Stomach Upset
Fatigue	Depression	Irritability	Tension
Sleeping problems	Stiff Neck	Cold Hands	Cold Feet
Diarrhea	Constipation	Fever	Hot Flashes
Cold Sweats	Lights bother eyes	Urinary Problem	Heartburn
Mood Swings	Menstrual Pain	Menstrual Irregularity	Ulcers

Family Health Profile:

At our office we are not only interested in your health and wellbeing but also that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children: ____

Spouse: ____

Mother: ____

Father: ____

Brother(s): ____

Sister (s): ____

Others: ____

Do you:

Drink Bottled water?	Yes	No	
Belong to health club?	Yes	No	
Use vitamins?	Yes	No	
Watch more than 5 hours of TV a week?	Yes	No	
Spend 1 or more hours on a computer daily ?	Yes	No	
Drink Soda?	Yes	No	(Diet or Regular)

What do you do for stress relief?

____

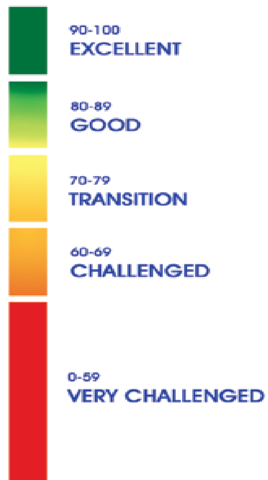
____

How many times a week do you exercise? ____

Are there any other health habits that you could share with us? ____________________________

____

Please mark an "X" where you believe your health is and an "O" where you would like to be.



I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature ____________________________________ Date: ______________________________