HEALTH HISTORY

13 and older

PLEASE FILL IN THE APPROPRIATE SPACES (All information is confidential)

Date:____/____/____

Name:_____ Referred By:_____
Address:_____ City:_____
State:_____ Zip:_____ Home Phone:(_____)_____
E-Mail:_____
D.O.B.____/____/____ Sex: M F Age:_____ Marital Status: S M D W #Children_____
Occupation:_____Employer:_____
Work Phone:(_____)_____ S.S.# _____
Spouse Name:_____

Are you seeking chiropractic care today as part of your wellness plan? Yes ( ) No ( )
Do you have a major complaint we need to know about? Yes ( ) No ( ) If yes please tell us_____
_____
How long have you had these conditions? _____ Date that it began:____/____/____
Have you had a similar condition before? Yes ( ) No ( ) When: ____/____/____
Is the condition related to: work accident ( ) auto accident ( )
Have you ever been under chiropractic care? Yes( ) No( ) If yes for what purpose?
_____
_____
When did you last see this chiropractor? ____/____/____
Why are you changing chiropractors?_____
_____
What surgeries have you had?_____
_____
List drugs you now take (prescription and non-prescription)_____
_____
Name other health care professional you have seen for this condition: _____
_____
Any other conditions we need to know about?_____
_____

HEALTH FUTURE

WHAT IS YOUR HEALTH PHILOSOPHY? (What should you do to be healthy?)
_____
_____
Do you do anything to insure that your nerve system is functioning properly?Yes( )No( )
If yes what? _____
_____
Do you exercise? Yes( ) No( ) If yes what exercise do you do and how often? _____
_____

Do you take any type of natural supplements, vitamins, minerals, ect.? Yes ( ) No( ) If yes what?_____

_____

What is your diet like? (What do you eat, whole foods, organic, vegetarian, ect.?)

_____

_____

Do you have a positive attitude? Yes( ) No( )

WHY DID YOU COME INTO OUR CLINIC AND WHAT ARE YOUR EXPECTATIONS OF US? _____

_____

_____

What are your favorite hobbies or activities?_____

_____

What would you like to do in your retirement?_____

_____

Who would you like to do this with? _____

_____

HOW WOULD YOU LIKE US TO HANDLE YOUR HEALTH?

____Relief Care (weeks) (help the symptom but do not fix the cause of the problem)
____Health Care (months) (correct the cause of the problem and stabilize your health)
____Wellness Care (lifetime) (correct the cause of the initial problem and continue into life time wellness care to optimize your quality of life)

On a scale of 1-10 (10 being the most, and 1 being the least)

____How committed are you at being at your optimum health potential?
____How important is it to you that your family be at their optimum health potential?
____How committed would you like us to be helping you reach your health goal?

PLEASE FEEL FREE TO DISCUSS OUR FEES. FEES ARE PAYABLE WHEN SERVICES ARE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE IN ADVANCE.

Signature:_____

_____
_____
_____
_____
_____
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