Health History

Name: _____DOB:_____Date: _____

Address: _____City: _____State: _____ Zip: _____

Email: _____Occupation: _____

Primary Phone: _____ Secondary Phone: _____

Married Single Partnered Dependent Children and ages: _____

Referred By: _____

Childhood History: (*Birth to 17)*

Any childhood illnesses?	**Yes**	**No**	_____
Any serious falls or sport injuries as a child?	**Yes**	**No**	_____
Were you exposed to significant emotional or chemical stress as a child?	**Yes**	**No**	_____
Any surgeries?	**Yes**	**No**	_____
Any prolonged use of medicine?	**Yes**	**No**	_____
Any car accidents as a child or teenager?	**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**

If yes, list here: _____

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

If yes, list here: _____

_____

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

What kind_____

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: _____ How often and what? _____

Sleep: _____ Hours per day? _____

General Health: _____

Please list any medications you are currently taking and why:

_____

_____

_____

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 Your Health History. 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? _____

Why is regaining your health important to you?

_____

Please check (✓) all symptoms you have had in the last month:

☐ Headaches	☐ High blood pressure	☐ Sinus congestion	☐ Neck pain/stiffness
☐ Pins and needles in arms	☐ Shoulder pain	☐ Upper/mid back pain	☐ Low back pain
☐ Dizziness	☐ Chest pain	☐ Ringing in ears	☐ TMJ pain
☐ Numbness/pain in fingers	☐ Numbness in toes	☐ Knee pain	☐ Elbow/wrist pain
☐ Anxiety	☐ Depression	☐ Ankle pain	☐ Foot pain
☐ Sleeping problems	☐ Sleep apnea/snoring	☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation	☐ Heartburn	☐ Hot Flashes
☐ Heart palpitations	☐ Loss of balance	☐ Urinary Problem	☐ Heartburn
☐ Mood Swings	☐ Menstrual Problems	☐ Other _____	

Your Health History:

Please circle any of the following health problems that you have or have had in the past:

thyroid, asthma, acid reflux or other digestive problems, high blood pressure, heart, stroke or circulatory problems,

dizziness, diabetes, hypoglycemia, arthritis, osteoporosis, prostate, PMS, medical implants, pacemaker, metal screws in joints,

cancer(explain)_____ Other conditions_____

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): _____

Do you:

Drink Coffee or Caffeinated Tea ? Yes No

Drink Soda? Yes No (Diet or Regular)

What do you do for stress relief?

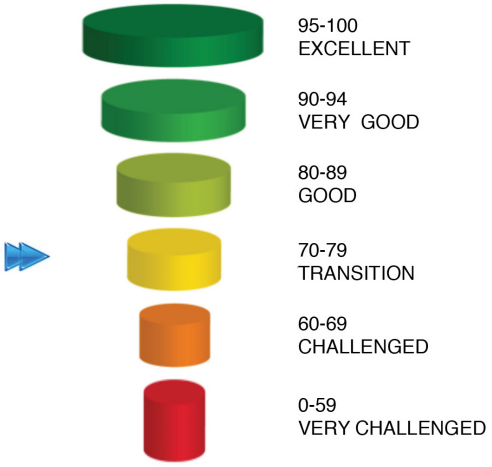
_____

_____

Are there any other health habits that you would like share with us? _____

_____

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



What are your health goals and how long do you think it will take to achieve them? _____

_____

_____

_____

_____

What things might you need to change to reach your goal?

a. _____

b. _____

c. _____

d. _____

Chiropractic

Four basic principles:

1. The body is self-healing. If you get a cut, it will heal. If a corpse gets a cut, it won't.
2. The brain and its nerve system are what run, regulate and EVERYTHING in your body.
3. Stress can overload & interfere with your nerve circuits – this is called a subluxation.
4. Chiropractic adjustments gently & systematically reverse this process.
5. Most drugs treat symptoms by suppressing them.
   The chiropractic adjustment does not suppress, but wakes up your ability to heal.
   A series of adjustments will be necessary.

My Specialty

Gentle but deep adjustments of primary areas of nerve stress, that allow your body to self-adjust other more secondary stress areas (often where you feel pain). A more non-invasive, elegant adjustment.

I have helped thousands over the past 40 + years. I can help you!

First visit – Discovery: Consultation, Physical Exam & Neurological Scanning.
I want to see why your very intelligent body is struggling to adapt to life's challenges, how this is affecting your health, and what we can do to help.

Second Visit – Report of Findings - Care Options - 1st Adjustment

I understand that the purpose of care in this clinic is not to cure a specific disease or condition, but revive the body's own ability to heal.

I also understand & agree that payment is always either prepaid or paid at the time of the visit, and that I am responsible for all bills incurred in this office.

If this patient is a child under 18 years of age, I being the parent or legal guardian of this patient hereby grant permission for my child to receive chiropractic care.

Printed Name	Signature	Date