BRYN MAWR CHIROPRACTIC - 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 _____	Serious falls or sport injuries?	Yes	No	_____
Significant emotional or chemical stress?	Yes	No _____	Surgeries?	Yes	No	_____
Prolonged use of medicine?	Yes	No _____	Car Accidents?	Yes	No	
Under regular chiropractic care?	Yes	No	Please share any additional information:			

_____

Adult – (18 to present)

Any auto or other significant accidents? **Yes** **No** _____ Any surgeries? Yes No _____

Medications currently taking and why? _____

Do you play adult sports? **Yes** **No** _____

Drink coffee or caffeinated tea? Yes No

On a scale of 1-10, describe your stress level (1=none, 10=extreme) Occupational _____ Personal ____

What do you do for stress relief? _____

Health Habits: Rate the following as Poor, Good, Excellent:

Diet: _____ Describe _____

Exercise: _____. How often and what? _____

Sleep: _____. Hours per day? _____ General Health_____

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 your life: _____

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

Why is regaining your health important to you? _____ _____

Symptoms - Please check (✓) all 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 had in the past month:

Thyroid	Asthma	Acid reflux	Digestive problems	High blood pressure
Heart	Stroke	Dizziness	Diabetes	Hypoglycemia
Arthritis	Osteoporosis	Prostate	PMS	Medical implants
Pacemaker	Metal screws	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): _____

I understand that the purpose of care in this clinic is not to cure a specific disease or condition, but revive my 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.

_____ _____ _____

Printed Name Signature Date

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