SEEDS OF HOPE FAMILY CHIROPRACTIC HEALTH HISTORY

Welcome! PLEASE PRINT CLEARLY **Today's Date_____**

PERSONAL DATA

First name_____MI: _____ Last name: _____Nickname _____

Gender M____ F_____ Age _____ Date of Birth _____ SS# (optional) _____

Current address_____ City _____ State_____ Zip _____

Home phone (____) _____ Cell phone (_____) _____Work Phone (____) _____ext _____

Preferred phone contact - ❑ Home ❑ Work ❑ Cell Email address_____

In which format do you prefer appointment reminders? Email ❑ Telephone ❑ Home ❑ Work ❑ Cell

Occupation_____Employer _____ Student F/T_____ P/T _____

Marital Status ❑ Single ❑ Divorced ❑ Widowed ❑ Married to: _____

Emergency contact _____Relationship to you_____

Names and Ages of Children _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

Please list your health concerns according to their severity	**Rate of severity 1 = mild 10 = worst**	**When did this episode start?**	**Did the problem begin with an injury?**	**% of the time pain is present**
1.				
2.				
3.				
4.				

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

_____

Since the problem started, is it**:** **About the same** **Getting Better** **Getting Worse** (circle applicable**)**

What have you done for this condition? Was it of benefit?

_____

I do (do not) have a family history of this or similar symptoms (please explain)

_____

Are these concerns affecting your life? (Please put a checkmark in front of all that apply

1. Do they cause **<u>you</u>:**

Moodiness
Irritability
Interrupted sleep
Restricted Daily Activities

2) Do they affect your **WORK:**

Decision Making
Poor attitude
Decreased Productivity
Unable to work long hours
Exhausted at end of day

3) Do they affect your **PERSONAL LIFE:**

Lose patience with spouse/children
Restricted household duties
Hinders ability to exercise/participate in Sports
Interferes with ability to participate in hobbies or other desired activities

On a scale of 1-10 how is this affecting your life? (circle)

Little affect 1 2 3 4 5 6 7 8 9 10 Great affect

Name ……. Today's date ……..

HEALTHCARE PRACTITIONER HISTORY

Have you consulted OR do you regularly consult any of the following providers?

Chiropractor ❑ Medical Doctor(s) ❑ Others ❑

Doctor's details: Name: Address:

When did you see them:

What did they say was wrong?

Did it help? What did they do?

Doctor's details: Name: Address:

When did you see them:

What did they say was wrong?

Did it help? What did they do?

(IF YOU NEED TO PROVIDE ADDITIONAL DOCTORS – PLEASE ATTACH A SEPARATE SHEET)

Please list your current or past health problems in these areas? Please explain:

Eyes/Ears/Nose/Throat …….

Vascular /Cardiovascular …….

Gastrointestinal ……..

Endocrine/Thyroid/Diabetes/Glands…….

Respiratory …….

Urinary/Kidney/Bladder……..

Reproductive ……

Skin/hair/nails..…….

Neurological (headaches/seizures/vertigo/stroke/tics)…….

Musculoskeletal (joints/muscles) ……..

Mental/Phychological (anxiety/bipolar/depression).....…….

Any history of cancer or other illnesses ……..

Any unexplained weight loss in the last 6 months Yes No

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The Primary system in the body which coordinates health is the CENTRAL NERVOUS SYSTEM, which is comprised of the brain, spinal cord and spinal nerves. The vertebrae (bones of the spinal column) surround and protect the delicate nervous system. Chiropractors are specialists trained in

Name …… **Today's date ……**

the 'early detection' of injury to the spine and nervous system. The information below will help us to see the types of **PHYSICAL, EMOTIONAL & BIOCHEMICAL STRESSES** you have experienced because accumulation of stress affects your health and ability to heal.

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please circle where and how you were birthed. (if you do not know, please skip to the next question)

Home	Natural	Hospital	C-Section	Forceps
Breech	Cord around neck	Prolonged Labor	Induced Labor	Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any **accidents, falls or injuries in your life** related to any of the following? (check all that apply)

❑ Work related ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

❑ Automobile ❑ daily life

If yes, state ***type of injury and date*****:** (*If this is from a recent auto accident, please provide name of insurance company)*

_____

_____

Have you ever **injured** your spine, head, neck, ribs, chest, upper or lower back, pelvis or hips? ❑ Y ❑ N

If yes, state ***type of injury and date:***

_____

_____

Have you ever **broken, fractured or sprained** any bones or joints? ❑ Y ❑ N

If yes, list ***body parts injured and dates:***

_____

_____

Have you ever been hospitalized? ❑ Y ❑ N

If yes, ***state reason and dates:*** _____

_____

What services were provided? WHEN WHY WHO HAS THE RESULTS

X Ray _____

MRI _____.

Other _____.

_____

Name…… **Today's date ……**

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Illness	Y	N

BIOCHEMICAL STRESS

Biochemical stress occurs when a substance that is toxic to the body is breathed, injected, taken by mouth, or placed on the skin (e.g. food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you **vaccinated?** ❑ Y ❑ N If yes, did you have a **reaction**? ❑ Y ❑ N

Have you been **exposed to** any of the following on a regular basis, (past or present)?

❑ Toxic chemicals ❑ Second hand smoke ❑ Drug therapy

❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list:_____

Do you have **allergies** to any foods? ❑ Y ❑ N **If yes, please list:** _____

_____

Do you **consume** any of the following presently?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

DRUG	CONDITION	DRUG	CONDITION
---	---	---	---
---	---	---	---
---	---	---	---

It is imperative that you list ALL medications as they may have an influence on your care.

QUALITY OF LIFE

How do you grade your **physical health**? ❑ Good ❑ Fair ❑ Poor

How do you grade your **emotional/mental health**? ❑ Good ❑ Fair ❑ Poor

How do you rate your overall **"quality of life"**? ❑ Good ❑ Fair ❑ Poor

Do you **exercise** regularly? If yes, how often? _____

Do you **miss meals**? If yes, how often? _____

Do you take **supplements**? If yes, please list:_____

Do you follow a **special dietary regime**? If yes, what? _____

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Aspects of wellness you want for yourself (please check all that apply)

- ❒ More Energy
- ❒ Better Concentration
- ❒ Improved digestion
- ❒ Easier breathing
- ❒ Deeper relaxation
- ❒ Better Sleep
- ❒ Enhanced emotional well-being
- ❒ Improved strength and endurance
- ❒ Better sports performance, reaction time/reflexes
- ❒ More balanced posture
- ❒ Freedom from pain
- ❒ Reduce/eliminate medication use
- ❒ Greater Resistance to disease
- ❒ Overall health improvement

I would like the following benefits from *Chiropractic Care* (check all that apply)

Relief of a symptom or problem	Relief and prevention of a symptom or problem
Healthier spine and nerve system	Optimal health on all levels

Physical, Emotional and Biochemical STRESSES, common in everyday life, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic Exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

FAMILY HEALTH

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 _____

Name …….. **Today's date ……**

FINANCIAL

Payment in full is expected on all FIRST VISIT services. All other fees are to be paid at time of service until other arrangements have been made and agreed upon in writing.

First visit fees: Comprehensive Exam $150 X Ray views: $30 - $40 per view (by necessity)

Please indicate your method of payment Cash __ Check ___ Credit Card ___

INSURANCE

Dr. Spratt is not a participating provider for any insurance company. However, if your insurance company covers chiropractic care, it is quite possible that they will reimburse you for some of our care if you submit your claims. We will be happy to assist you in this process by giving you a 'Superbill' which is a receipt of services (which will include procedure and diagnosis codes) that you can send to your insurance company. Insurance coverage varies greatly. By providing you with a "Superbill', we cannot guarantee that you will receive any reimbursement from your insurance company. If you do not have chiropractic care in your policy, or when your plan coverage is exhausted, we have several affordable plans to present to you.

Please indicate below if you have a policy or a plan which could reimburse you for your care at this office

Health Insurance __ Auto Accident __ Worker's Compensation __

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. Michael Spratt, permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, diagnostic X-Rays and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature_____ **Today's Date**_____

Thank you for choosing Seeds of Hope Family Chiropractic.Let us help you to live your best life possible. We look forward to serving you with the utmost care and compassion.