Grant Family Chiropractic

Health History

Name: _____DOB:_____Date: _____

Address: _____City: _____State: _____ Zip: _____

Email: _____ GFC Newsletter? Yes / No Occupation: _____

Phone: _____Cell: _____Work Phone: _____
May we leave a message? Y / N May we leave a message? Y / N May we leave a message? Y / N

Married Single Divorced Widowed Kids: _____

Spouse's Name & Contact Info: _____ Children?_____

Referred By: _____

Healthcare History:

Have you had previous chiropractic care? Yes / No

Who was your previous Chiropractor? _____

Where?_____ When? _____ X-Rays taken in the last 6 months? Yes / No

What was the primary reason for consulting that office?

_____Relief Care – Symptom relief of pain or discomfort

_____Corrective Care – Correcting, relieving and stabilizing spinal, joint and postural issues

_____Wellness Care – Maximizing the body's ability for optimal healing and function

Do you feel your previous chiropractic care was effective? Yes / No

Please Explain:_____

Are you wearing: Heal Lifts / Custom Orthotics

Family Doctor:_____

Date & Reason of last visit:_____

May we contact your family doctor regarding you care at our office if necessary? Yes / No

Naturopathic Doctor:_____

Date & Reason of last visit:_____

Other Specialists & Healthcare Professionals:

Name:_____

Professional Designation:_____

Date & Reason of last visit:_____

Name:_____

Professional Designation:_____

Date & Reason of last visit:_____

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:

_____

_____

_____

Pregnancy: (women only)

Are you pregnant? _____Yes _____No

If Yes – Please stop and fill out pregnancy paperwork:

If No – When was your last menstrual cycle? _____

Adult History: (18 to present)

Diet: _____ **What do you eat?** _____

General Health: Poor / Fair / Good / Excellent

Do/did you play adult sports? Yes / No → **Which Sports Played?**_____

Height:_____ Weight:_____ BMI:_____
(Office Use Only)

Lifestyle Information:

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional & chemical stresses common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate nervous system. The result is a condition called Vertebral Subluxation. The remainder of the intake form addresses the possible factors which may contribute to the vertebral subluxation in your spine which may be impeding your body's ability to heal.

Physical Profile:

On a scale of 1 – 10 describe your stress level: → 0___1___2___3___4___5___6___7___8___9___10___

(1 = no stress / 10 = extreme stress)

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:

_____

_____

How do you rate your current pain? → 0___1___2___3___4___5___6___7___8___9___10___

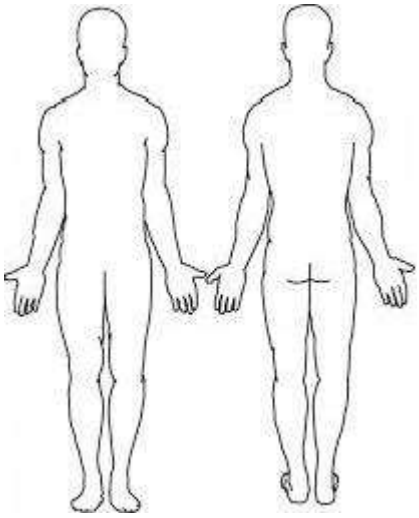
(0=No Pain / 10 = Emergency Room Pain)

How long have you been experiencing this pain? → 1 2 3 4 5 6 Days / 1 2 3 4 5 6 Wks / 1 2 3 4 5 6 Mths / 1 2 3 4 5 6 Yrs

Is your pain: _____ getting worse _____ getting better _____intermittent _____constant

How often do you experience your pain each day? _____0-25% _____26-50% _____51-75% _____76-100%

Please mark on the diagram where your current pain is:



Does this interfere with:

___Work ___Sleep ___Walking

___Hobbies ___Leisure ___Day to Day

___Other

Have you seen anyone else for this issue?

Yes / No If yes, who?

_____

_____

_____

_____

Do you feel/have: Pain Numbness Tingling Aches Stiffness Sharp Dull

Throbbing Burning Cramps Swelling Stabbing Other:_____

What makes your symptoms worse: Sitting Standing Walking Bending Lying Down Weather

Other:_____

What makes your symptoms better: Sitting Standing Walking Bending Lying Down Weather

Other:_____

Are you happy with your current physical appearance & abilities? Yes / No

Frequency of Exercise: Cardio? Days per Week: 1 / 2 / 3 / 4 / 5 / 6 / 7
Weight Bearing? Days per Week: 1 / 2 / 3 / 4 / 5 / 6 / 7

Do you stretch after exercise or after other activities? Yes / No / Sometimes

Hours of Sleep / Night: < 6 / 7-9 / 10+ Do you feel refreshed upon waking? Yes / No / Sometimes

Age of Mattress: _____ Which position do you sleep? Back / Belly / Side (right left both)

Number of Hours Commuting: 0-2 / 3-5 / 6-8 / 9-11 / 12+

Number of Hours at a Desk/Computer per week: 0 / 1-5 / 6-10 / 11-20 / 21-40 /41+

Number of Hours on Smart Device or Tablet per week: 0 / 1-5 / 6-10 / 11-20 / 21-40 /41+

Do you primarily: Sit / Stand / Perform Repetitive Tasks Tasks:_____

Have you ever been hospitalized or had surgery? Yes / No

When:_____

Have you ever been in a motor vehicle accident (even if it was minor)? Yes / No

If yes, what kind and when?_____

Were you evaluated and treated after each accident? Yes / No

Past injuries can affect present health (please circle all that apply):

Falls/accidents Head injuries Fights Surgery Sports injuries Broken bones

Dislocations Spinal tap Traction Concussion Knocked Unconscious Other

If YES, to any of the above, please describe:_____

_____

Do you have, or have you had, any of the following (please circle all that apply)?

Pneumonia Influenza Pleurisy Chicken Pox Rheumatic Fever Smallpox

Eczema Epilepsy Depression Stroke Rashes Cancer

Thyroid Disease Anemia Arthritis Colitis Allergies Polio

Heart Disease Whooping Cough Diabetes Mumps

Chemical Profile:

Were you vaccinated as a child? Yes / No **Any adverse reactions to vaccines?** Yes / No

Do you have annual flu shots? Yes / No **Do you take antibiotics?** Yes / No

How many glasses of water per day? 0 / 1-3 / 4-6 / 7-9 / 10+

How many glasses of caffeinated beverages per day? 0 / 1-3 / 4-6 / 7-9 / 10+

How many glasses of cow's milk / juice / pop per day? 0 / 1-3 / 4-6 / 7-9 / 10+

Do you eat gluten? Yes / No / Trying to Eliminate **Do you eat dairy?** Yes / No / Trying to Eliminate

Do you eat refined sugars (white sugar, white bread, pasta)? Yes / No / Trying to Eliminate

Do you eat boxed/frozen foods? Yes / No / Trying to Eliminate

Do you eat any artificial sweeteners (Splenda, aspartame, diet soda, etc.)? Yes / No

Any food/drink allergies, sensitivities intolerances? Yes / No

Do you choose organic foods? Yes / No

Do you smoke? Yes / No **Are you or have you been exposed to second-hand smoke?** Yes / No

Do you drink alcohol? Yes / No **Do you take a probiotic daily?** Yes / No

Do you take D3 daily? Yes / No **Do you take Omega 3 (fish oil) daily?** Yes / No

Please list any medications:

Medication Name	**Dose**	**Frequency**
1)	mg	/
2)	mg	/
3)	mg	/
4)	mg	/
5)	mg	/

Please list any supplements:

Supplement Name	**Dose**	**Frequency**
1)	mg	/
2)	mg	/
3)	mg	/
4)	mg	/
5)	mg	/

Emotional Profile:

Rate your current level of **PERSONAL STRESS** in your life: None / Low / Moderate / High
Rate your current level of **RELATIONSHIP STRESS** in your life: None / Low / Moderate / High
Rate your current level of **FINANCAL STRESS** in your life: None / Low / Moderate / High
Rate your current level of **HEALTH STRESS** in your life: None / Low / Moderate / High
Rate your current level of **FAMILY STRESS** in your life: None / Low / Moderate / High
Rate your current level of **CAREER STRESS** in your life: None / Low / Moderate / High

Do you feel you have a supportive network of friends & family? Yes / No
Do you feel you have healthy coping strategies for life stress? Yes / No
Do you suffer from any emotional conditions (Bipolar, Depression, Anxiety, Nervousness)? Yes / No
Please Describe:_____

Family Health Profile:

At our office we are not only interested in your health and wellbeing but also those of your family and loved ones.
Please mention below any current health conditions, concerns and family health history you may have about your:
Child(ren): _____
Spouse: _____
Mother: _____
Father: _____
Brother(s): _____
Sister (s): _____

Please check (✓) all symptoms you have had in the last 90 days, even if they do not seem related to your current problem:

- ☐ ADD/ADHD
- ☐ Allergies
- ☐ Anxiety
- ☐ Brachial Neuritis
- ☐ Buzzing in ears
- ☐ Chronic Fatigue
- ☐ Cold Hands
- ☐ Depression
- ☐ Dizziness
- ☐ Ear Infections
- ☐ Epilepsy / Seizures
- ☐ Fainting / Vertigo
- ☐ Fatigue
- ☐ Headaches
  How often?_____
- ☐ High Blood Pressure
- ☐ Irritability
- ☐ Increase in Colds
- ☐ Jaw / TMJ Issues
- ☐ Light bothers eyes
- ☐ Loss of balance
- ☐ Loss of smell
- ☐ Loss of taste
- ☐ Memory Loss
- ☐ Migraines
  How often?_____
- ☐ Mood Swings
- ☐ Neck pain
- ☐ Nervousness
- ☐ Numbness in fingers
- ☐ Pain in Arms
- ☐ Pins and needles in arms
- ☐ Poor Metabolism
- ☐ Poor Weight Management
- ☐ Ringing in ears
- ☐ Sinus Trouble
- ☐ Stiff Neck
- ☐ Stiff Shoulders
- ☐ Speech Problems
- ☐ Other:
  _____

- ☐ Asthma
- ☐ Blood Sugar Problems
- ☐ Breathing Trouble
- ☐ Bronchitis
- ☐ Chest Pain
- ☐ Cold Sweats
- ☐ Colitis
- ☐ Congestion
- ☐ Cramps
- ☐ Fever
- ☐ Functional Heart Condition
- ☐ Gallbladder Issues
- ☐ Heartburn
- ☐ Hernias
  (abdom'l, inguinal, hiatal)
- ☐ Circulation Issues
- ☐ Hot Flashes
- ☐ Impotency
- ☐ Irritable Bowel Syndrome
- ☐ Jaundice
- ☐ Kidney Issues
- ☐ Liver Condition
- ☐ Nephritis
- ☐ Pneumonia
- ☐ Pyelitis
- ☐ Radiating Pain in Forearms/Wrists/Hands
- ☐ Reflux/GERD
- ☐ Reproductive Issues
- ☐ Skin Issues
- ☐ Sleeping Issues
- ☐ Stomach Upset/Pain
- ☐ Tension
- ☐ Ulcers
- ☐ Other:
  _____

- ☐ Back Pain
- ☐ Bladder / Bedwetting
- ☐ Cold Feet
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult/Painful/Too Frequent Urination
- ☐ Disc Degeneration
- ☐ Erectile Dysfunction
- ☐ Foot/Ankle/Knee Issues
- ☐ Hemorrhoids
- ☐ Herniation (spinal)
- ☐ Let Weakness / Cramps
- ☐ Lumbo-pelvic Pain
- ☐ Menstrual Issues
- ☐ Numbness in Toes
- ☐ Pins / Needles in Legs
- ☐ Poor Circulation in Legs
- ☐ Prostrate
- ☐ Sacro-Iliac Pain
- ☐ Sciatica / Radiating Pain
- ☐ Spinal Curvatures
- ☐ Swollen Ankles
- ☐ Urinary Issues
- ☐ Other:
  _____

What do you do for stress relief?_____

_____

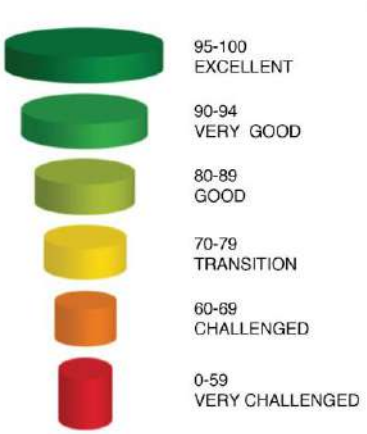
_____

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

_____

The practice of chiropractic is based upon the location and adjustment of vertebral subluxations. These spinal subluxations are caused by any stress to which your body cannot adapt. These stresses may be **physical**, **chemical**, or **emotional** in nature.

Please mark "X" for your CURRENT health
Please mark "O" for your health GOAL



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 services rendered is due at the time of service and cannot be deferred to a later date.

Signature _____ Date: _____

Financial Responsibility:

Who is responsible for payment? _____

Responsible Party Relationship to Patient: Self / Spouse / Parent / Other

The above is accurate to the best of my knowledge.

_____ _____
(signature) (date)

I, parent/guardian, give permission for minor's care.

_____ _____
(signature) (date)