Grant Family Chiropractic

Health History

Name: _____DOB:_____Date: _____

Address: _____City: _____State: _____ Zip: _____

Email: _____GFC Newsletter?___Yes___No___Occupation: _____

Phone: _____Cell: _____Work Phone: _____

Married Single Divorced Widowed Kids: _____

Spouse's Name & Contact Info: _____ Referred By: _____

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:

Are you pregnant? _____Yes _____No

If Yes – Please stop and fill out pregnancy paperwork:

If No – When was your last menstrual cycle? _____

Adult: (18 to present)

Do/did you smoke?	**Yes**	**No**	**Rate these following as Poor, Good, Excellent:**
Do/did you drink alcohol?	**Yes**	**No**	**Diet:** _____ **What do you eat?** _____
Have you been in any accidents?	**Yes**	**No**	**Exercise:** _Y / N_ **When and what?** _____

Height:_____ Weight:_____ BMI:_____

Have you had any surgery? **Yes** **No** **Sleep:** Good Bad **Hours per day?** 1 2 3 4 5 6 7 8 9

If yes, list here:_____ **General Health:** Poor / Fair / Good / Excellent

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

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)

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

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:

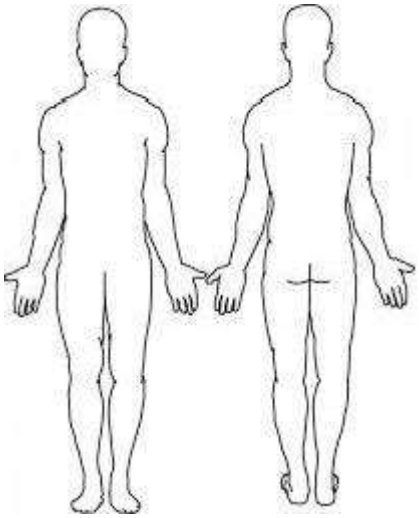
_____

_____

Is your pain: _____ getting worse _____improving _____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 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:_____

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

Pneumonia	Influenza	Pleurisy	Chicken Pox	Rheumatic Fever	Small Pox
Eczema	Epilepsy	Depression	Stroke	Rashes	Cancer
Thyroid Disease	Anemia	Arthritis	Colitis	Allergies	Polio
Heart Disease	Whooping Cough	Diabetes	Mumps		

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:_____

_____

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	/

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 Bottled water?	Yes	No
Belong to health club?	Yes	No
Use vitamins?	Yes	No
Watch more than 5 hours of TV a week?	Yes	No
Spend 1 or more hours on a computer daily ?	Yes	No
Drink Soda?	Yes	No

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

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

  _____

- ☐ Chest Pain
- ☐ Tension
- ☐ Sleeping problems
- ☐ Fever
- ☐ Hot Flashes
- ☐ Cold Sweats
- ☐ Ulcers
- ☐ Bronchitis
- ☐ Heartburn
- ☐ Stomach Upset
- ☐ Pneumonia
- ☐ Congestion
- ☐ Reflux / GERD
- ☐ Asthma
- ☐ Breathing Trouble
- ☐ Radiating Pain in Forearms/Wrists/Hands
- ☐ Functional Heart Condition
- ☐ Gallbladder Issues
- ☐ Jaundice
- ☐ Liver Conditions
- ☐ Blood Pressure / Circulation Issues
- ☐ Blood Sugar Problems
- ☐ Allergies Hyperactivity
- ☐ Kidney Issues
- ☐ Nephritis
- ☐ Pyelitis
- ☐ Chronic Fatigue
- ☐ Skin Issues
- ☐ Constipation
- ☐ Irritable Bowel Syndrome
- ☐ Colitis
- ☐ Cramps
- ☐ Diarrhea
- ☐ Hernias
- ☐ Bladder Issues
- ☐ Reproductive Issues
- ☐ Impotency
- ☐ Menstrual Issues
- ☐ Other:

  _____

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

  _____

What do you do for stress relief?_____

_____

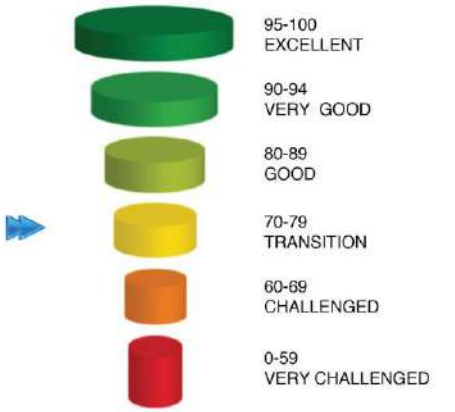
_____

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)