



PERSONAL AND FAMILY HEALTH HISTORY

Today's Date: _____

Name: _____ Date of Birth : _____ Age _____ S M D W
 Address: _____ Phone: (H) _____ (W/C) _____
 City: _____ Your Employer: _____
 State: _____ Zip: _____ Occupation: _____
 Email: _____ Spouse's Name: _____
 Social Security # _____ Spouse's Occupation: _____
 Referred By: _____ Name of Insurance Co. _____
 Number of Children and Ages: _____ Have they had previous Chiropractic Care?
 Name _____ Age _____ Yes / No Reason _____
 Name _____ Age _____ Yes / No Reason _____
 Name _____ Age _____ Yes / No Reason _____
 Name _____ Age _____ Yes / No Reason _____

Why this form is important – As a family wellness chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we offer you and your family the opportunity for a **lifetime of health, happiness and vitality**.

On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Often, the effects are so gradual that they are not felt until they become serious, and sometimes not until it's too late! Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better assess your current status and more accurately determine what course of care will best help you reach your true health potential. Many health challenges people face later in life may have their origins in stresses from the developmental years, some even starting at birth.

Circle all that Apply

1. Was Your Birth Traumatic?

	Patient	Spouse	Child#1	Child#2	Child#3	Comments/Details
Long or difficult delivery?	Y	Y	Y	Y	Y	_____
Mother smoked/drank in pregnancy?	Y	Y	Y	Y	Y	_____
Forceps / vacuum extractor?	Y	Y	Y	Y	Y	_____
Caesarian section?	Y	Y	Y	Y	Y	_____
Breach/cephalic?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery?	Y	Y	Y	Y	Y	_____
Induced Labor / epidural?	Y	Y	Y	Y	Y	_____
Other complications?	Y	Y	Y	Y	Y	_____

2. Growth and Development (Childhood years: Ages 0-17 years) If Yes, please describe details!

Did you ever:

Receive chiropractic care?	Y	_____
Fall out of bed or while learning to walk?	Y	_____
Fall down steps, out of a tree or off bike?	Y	_____
Have any other falls or accidents?	Y	_____
Recurrent childhood illness/sickness?	Y	_____
Have Surgery? (dates, type)	Y	_____
Take drugs? (e.g. antibiotics, vaccines)	Y	_____
Bullied by your siblings/ bang your head?	Y	_____
Child abuse or spankings?	Y	_____
Chair pulled out when sitting?	Y	_____
Yanked by your arm or pulled ear/chin?	Y	_____
Experience other traumas/ stress?	Y	_____

3. Current Health Habits (Adult years: Ages 18 to present) If Yes, please describe details!

Did/do you:

Utilize chiropractic care (prior to today)?	Y	_____
Eat healthy foods regularly?	Y	_____

Drink 8-10 glasses of water daily?	Y	_____
Exercise regularly? (type, duration)	Y	_____
Smoke? (amount each day)	Y	_____
Drink? (# drinks each week)	Y	_____
Auto accidents? (dates)	Y	_____
Drugs? (List prescriptive/ Non-Prescript)	Y	_____
Surgery? (dates)	Y	_____
Side effects from drugs or surgery?	Y	_____
Sleeping problems? (nightmares?)	Y	_____
Have/had occupational/ work stress?	Y	_____
Sports or hobby injuries? (dates, type)	Y	_____

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

Present complaint (Reason for your visit today) _____

How long have you suffered with this problem? _____

What have you tried to resolve this problem but **DID NOT** work? _____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____

Does it interfere with... work family hobbies life exercise other _____

What activities make this problem worse? _____

What activities make this problem better? _____

How much older does this make you feel? _____

On a scale of 1 to 10, with 10 being the highest, rate your commitment in helping us solve this problem: _____

OTHER COMPLAINTS (even if they do not seem related to your current condition):

Low Back Pain	Tension Across Shoulders	Weight Trouble	Digestive Problems
Allergies/Asthma	Numbing/Tingling in Arms/ Hands	Nervousness	Pain Between Shoulder Blades
Neck Pain	Numbing/Tingling in Legs or Feet	Irritability	Tension/ Migraine Headaches or Sinus
Frequent Colds/Infections	Dizziness	Menstrual Problems	Difficulty Sleeping
Tired, Fatigued	Ear Infections or Ringing/Buzzing	Stomach/Bowel	Difficulty bending/lifting
High Blood Pressure	Fibromyalgia/ Muscle Spasm	Depression	Inability to participate in Sports/ Hobbies

As a result of my Chiropractic Care, I would like to: (Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Feel better quickly | <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy |
| <input type="checkbox"/> Have a healthier spine | <input type="checkbox"/> Live a healthier, more active lifestyle |

In addition to the main reason for your visit today, what are your current health goals? (Get out of pain, lose weight, eat healthier, quit smoking, walk 5 miles, etc.) _____

Favorite hobbies & interests _____

Are you as healthy (or healthier) today as you were 5 years ago? [] Yes [] No [] Don't Know

If yes, what strategies have you used? _____

Will you be as healthy (or healthier) as you are today, 5 years from now? [] Yes [] No [] Don't Know

If yes, what strategies will you implement to get there? _____

I certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible.

Signed _____ Date _____ / _____ / _____