

Health History

NAME _____ DATE _____
ADDRESS _____ CITY/STATE _____ ZIP _____
HOME PHONE _____ MOBILE PHONE _____
WORK PHONE/S _____ BIRTHDATE _____
OCCUPATION _____ EMPLOYER _____
ADDRESS _____ CITY/STATE _____ ZIP _____
SPOUSE _____ CHILDREN (NAMES/AGES) _____

E-MAIL ADDRESS _____
WHO REFERRED YOU TO US? _____
PAST CHIROPRACTIC CARE? YES/NO DR.'S NAME/LOCATION _____

LAST VISIT _____
CURRENT MEDICAL CARE? YES/NO WHY? _____
CURRENT DRUGS/MEDICATION _____
REASON FOR CONSULTING THIS OFFICE _____

**PLEASE CHECK THE ONE CHOICE THAT MOST CLOSELY DESCRIBES
YOUR CURRENT GOALS FOR HEALTH/WELLBEING.**

- I am only concerned about relief of a particular symptom.
- I am only concerned about relief of a particular symptom, and preventing its return.
- I want optimum health and wellbeing on every level available to me.

WE ACCEPT PAYMENT BY CASH, CHECK AND CREDIT CARD

I understand that all services are to be paid in full at the time of service,
unless other arrangements have been made and agreed upon in writing.

Signature _____ Date _____

- ❖ The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.
- ❖ This interference is most commonly caused by vertebral subluxations, resulting from physical, chemical or emotional stress.
- ❖ The practice of chiropractic is based on locating and reducing the vertebral subluxation, which causes nerve system interference.

Please check any that apply

PLEASE TELL US ABOUT ANY STRESS AT YOUR BIRTH:

- | | |
|--|--|
| <input type="checkbox"/> Drugs/medicine/tobacco/alcohol in pregnancy
<input type="checkbox"/> Labor chemically induced?
<input type="checkbox"/> Forceps/Vacuum Extraction/C-section
<input type="checkbox"/> Premature delivery?
<input type="checkbox"/> Vaccinations?
<input type="checkbox"/> Falls in first year of life?
<input type="checkbox"/> Any health related problems? | Explain: _____

_____ |
|--|--|

PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH CHILDHOOD:

- | | |
|---|---|
| <input type="checkbox"/> Any falls or injuries?
<input type="checkbox"/> Allergy/Asthma or Respiratory problems?
<input type="checkbox"/> Ear infections?
<input type="checkbox"/> Digestive problems?
<input type="checkbox"/> Hyperactivity?
<input type="checkbox"/> Any other health related problems? | Explain _____

_____ |
|---|---|

PLEASE TELL US ABOUT ANY STRESS UP TO PRESENT:

- | | |
|--|---|
| <input type="checkbox"/> Auto Accident or Injury?
<input type="checkbox"/> Work Injury?
<input type="checkbox"/> Sports Injury?
<input type="checkbox"/> Work Stress?
<input type="checkbox"/> Family/Home Stress?
<input type="checkbox"/> Prescription Drug Use?
<input type="checkbox"/> Non-Prescription Drug Use?
<input type="checkbox"/> Ever Hospitalized?
<input type="checkbox"/> Surgery?
<input type="checkbox"/> Any Major Illness?
<input type="checkbox"/> Reoccurring Illnesses?
<input type="checkbox"/> Limited Exercise?
<input type="checkbox"/> Poor Nutrition? | Explain _____

_____ |
|--|---|

Anything else? _____
