

Personal & Health History

(Please print)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ - _____ E-Mail Address: _____

Age: _____ Birth Date: _____ Sex: M F

SS#: _____ Marital: S M D W Spouse's Name: _____

Children & ages: _____

Employer: _____ Occupation: _____

Work Phone: _____ - _____ Cell Phone: _____ - _____

Activities/sports/hobbies: _____

Family's activities/interests: _____

Who will be responsible for your bill? Self ___ Spouse ___ Parent ___ Other _____

I intend to pay for my care by: Cash ___ Check ___ Credit Card: VISA MC AMEX DISC

Will there be an insurance claim involved? Yes / No

Type Policy: Personal ___ Group Health ___ Auto ___ Medicare ___ Personal Injury ___

I was referred to this office by: _____

I have heard about your office from: (please circle all that apply) Newspaper Mailing Internet
Phonebook Friend Location Other _____

Health History:

My reason for today's visit is: _____

How is this affecting your life/activities? _____

Physical Stress:

My birth was: Normal ___ Difficult ___ Drug Induced ___ C Section ___ Forceps/Suction ___

Prolonged _____ Additional Information: _____

List any falls, impacts, sports injuries or broken bones. When?:

Accidents: (Auto, Motorcycle, Bike, Bus, etc. Please provide dates and severity of injuries.)

Physical Stresses:

How many hours do you sit during the day? _____ How much physical activity do you get? _____

How often do you exercise? _____ What type? _____

Hospitalizations/surgeries: (dates and reason) _____

Do you still have all of your body parts: (tonsils, appendix, etc.) Yes / No explain _____

List Prolonged or frequent childhood illnesses: (Ear Infections, Asthma, Allergies, etc.) _____

Chemical Stresses:

Vaccinations: No / Yes (which ones?) _____

Are you taking any medication now? No / Yes (what & why?) _____

Allergies: No / Yes To what? _____

Rate your diet on a scale of 1—10, with 1 being nothing but fast and processed foods and 10 being a diet consisting primarily of organic fruits and vegetables, whole grains and lean meats _____

I: Smoke ___ packs/day Drink alcohol ___ Diet regularly ___ Caffeine (coffee/tea/soda) ___ NutraSweet ___

Work with toxic chemicals ___ Commute in traffic (1/2 hour or more) ___

Mental Stresses:

Known psychological disorders: _____

I would rate my level of mental stress: Very High ___ High ___ Moderate ___ Low ___ Very Low ___

On a scale of 1 (low) to 5 (high) how would you rate your level of stress (lifetime) from:

Childhood 1 2 3 4 5 Relationships 1 2 3 4 5 Work 1 2 3 4 5 Family 1 2 3 4 5

Lifestyle 1 2 3 4 5 Being Sick 1 2 3 4 5

Previous Health Care:

Family Physician: Dr. _____ Phone # (if known) ___ - _____ Last visit: _____

Previous Chiropractic Care: Dr. _____ Phone # (if known) ___ - _____ Last visit: _____

Reason for care _____ How long under care _____

Would you object to us conferring with your previous or other physicians about your care if necessary? No Yes

Expectations for your care here: Relief Only ___ Correction of Problem ___ Prevention of Health Problems ___

Family Wellness Care ___ Other _____

All of the statements made on this form are accurate and complete to the best of my recollection.

Patient/Parent/Guardian: _____ **Date:** _____