

Chiropractic ~ Health History

250 N Main St #D ~ City CA 95_ _ _

(707) 367-6166

doctoryourname@yahoo.com

Name (please print): _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail Address: _____

Birth Date: _____ Age _____ SS# _____

Height _____ Weight _____

Home Phone: _____ Work Phone: _____

Name of Employer _____ Occupation: _____

Marital Status: S M D W # of children: _____

Spouse/Partner Name _____ Spouse/Partner Age _____

Financial Information: Who is responsible for this account? _____

Reason Seeking Care: Pain/Injury Related YES NO Wellness/Health Maintenance YES NO

Accidents: Please list other accidents, include dates. (car, bicycle, motorcycle, sports, falls at work or home)

Surgeries/Conditions: Please list major surgeries, broken bones or conditions, include dates.

Medications: Please list prescription & over-the-counter medications you are currently taking & their purpose.

Have you been to a chiropractor before? YES NO

Briefly describe that experience:

Did the last chiropractor adjust your spine? YES NO

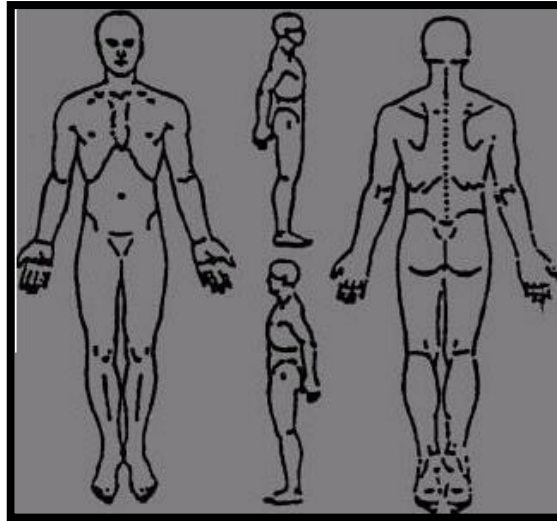
If yes, was there a "popping" sound when they adjusted you? YES NO

If yes please explain to the best of your ability what causes that "popping" sound:

Expectations of care. How many visits to our office do you anticipate? _____

If you are here due to an injury or pain please describe what happened:

Please mark your areas of pain on the figures by indicating the appropriate location of pain and the symbol that best describes your discomfort.



- Sharp & Stabbing A
- Dull & Achy B
- Pins & Needles C
- Numbness D
- Temperature Change E

Please score all of the following on a scale of 1-10, based on your current condition.

- Pain:** 1=no pain, 10=worst pain you have ever had _____
- Personal care:** (washing, dressing, etc.) _____
- 1=I can take care of myself with no extra pain, 10=I can't take care of myself at all _____
- Lifting:** 1=I can lift with no extra pain, 10=I can't lift at all due to _____
- Reading:** 1=I can read with no extra pain, 10= I can't read at all due to pain _____
- Headaches:** 1=no headaches, 10=worst headaches I have ever had _____
- Concentration:** 1=I can concentrate fully, 10=I can't concentrate at all _____
- Work:** 1=I can work as much as I want, 10=I can't work at all _____
- Driving:** 1=I can drive with no pain, 10=I can't drive due to pain _____
- Sleeping:** 1=I sleep fine, 10=I can't sleep at all _____

If you CAN POSSIBLY answer YES, circle YES If you MUST answer NO, circle NO
 Please answer all questions. If you are not sure do your best.

- Has your eyesight blacked out completely?.....YES NO
- Have you fainted more than twice in your life? YES NO
- Were you ever knocked unconscious?.....YES NO
- Are you hard of hearing? YES NO
- Do you have allergies?.....YES NO
- Have you ever coughed up blood? YES NO
- Have you suffered frequent cramps in your legs? YES NO
- Has a doctor ever said you had heart problems? YES NO
- Has a doctor ever said you had ulcers?.....YES NO
- Does pressure or pain in your head often make life miserable? YES NO
- Have you or a family member ever had convulsions or epilepsy? Who?.....YES NO
- Did a doctor ever treat you for a tumor or cancer? YES NO
- Are you frequently ill?.....YES NO
- Are you considered a nervous person? YES NO
- Has a doctor ever said your blood pressure was too high..... YES NO
- Have you been told you have osteoporosis? YES NO
- Have you been told you have rheumatoid arthritis?..... YES NO

Health Survey

In our chiropractic office we provide many services for your health. To get an idea of what you want and expect please take the following survey.

How would you rate your current health? Poor Fair Average Good Excellent

Do you want to live a long & healthy life? Yes No

If you answered yes above, how much time **per day** outside our office are you willing to commit to this goal?

_____hours _____minutes

Please score yourself from 1 to 10 below in each health category and then indicate if you are interested in receiving help in these areas. You can select as many or as few as you like.

Musculoskeletal pain: 1 2 3 4 5 6 7 8 9 10 (1 no pain at all, 10 extreme pain)

I would like help and/or info on decreasing my pain: Yes No

Diet and nutrition: 1 2 3 4 5 6 7 8 9 10 (1 horrible diet, 10 excellent diet)

I would like help and/or info on improving my diet and nutrition: Yes No

Exercise program: 1 2 3 4 5 6 7 8 9 10 (1 horrible exercise habits, 10 excellent exercise habits)

I would like help and/or info on exercise: Yes No

Ability to sleep well: 1 2 3 4 5 6 7 8 9 10 (1 horrible sleeper, 10 excellent sleeper)

I would like help and/or info on getting a good nights sleep: Yes No

Stress level: 1 2 3 4 5 6 7 8 9 10 (1 no stress at all, 10 extreme stress)

I would like help and/or info on decreasing my stress: Yes No

Headache frequency: 1 2 3 4 5 6 7 8 9 10 (1 constant headaches, 10 never)

I would like help and/or info on decreasing my headaches: Yes No

Pharmaceutical drug intake: 1 2 3 4 5 6 7 8 9 10 (1 daily intake, 10 never)

I would like help and/or info on alternative solutions: Yes No

Energy Level: 1 2 3 4 5 6 7 8 9 10 (1 no energy at all, 10 endless energy)

I would like help and/or info on increasing my energy level: Yes No

Other areas of health that you may need help:

Sign: _____

Date: _____