Personal Health History

Name ____
Date _________________
Address ______________________________________
City ____________________ State ____ Zip ________
Phone: (H) _______________ (W) ________________
E-mail ____
Date of Birth _______________ (Age ______)

Referred By __________________________________
Social Security # ______________________________
Occupation ___________________________________
Employer _____________________________________
Marital Status S M D W
Spouse's Name ________________________________
Spouse's Occupation ___________________________

Number of Children and Ages

Name ____________________________ Age ___
Name ____________________________ Age ___
Name ____________________________ Age ___

Previous Chiropractic Care? Y N

Reason ____________________________
____
____

As a Family Wellness/Lifestyle-Based Chiropractic office, we focus on helping families optimally express their inborn human potential through an optimally functioning nervous system. Throughout our lives, we experience emotional, physical, and chemical stresses that can become "trapped" and cause nerve distortion patterns, which include alterations in perceptions and adaptations, that result in a diminished quality of life, capacity for healing, self-regulation, self-organization, and making the most constructive choices for one's life, health, and emotions. Most times the effects are gradual, not even felt until they become serious. From the time of your initial examination, and throughout your lifetime involvement with chiropractic wellness care, we will be committed to helping you achieve higher levels of spinal and neural integrity so that you can live the quality of life you deserve. Answering the following questions will give us an insight into specific stresses you have faced in your lifetime, allowing us to better assess the challenges to the expression of your inborn potential.

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

Was Your Birth Traumatic?

1. Long / Difficult Delivery? Y N
2. Forceps / Vacuum Extraction? Y N
3. Caesarian? Y N
4. Breach / Cephalic? Y N
5. Home Birth? Y N
6. Mother given Drugs During Delivery? Y N
7. Induced Labor? Y N

Your Childhood Years

Did you ever...

8. Have Chiropractic Care as a Child? Y N
9. Have any Serious Falls? Y N
10. Receive Vaccinations? Y N
11. Breastfeed? Y N
12. Have Childhood Illnesses? Y N
13. Have any Accidents? Y N
14. Have Surgery? Y N
15. Take Drugs / Medications? Y N
16. Fall While Learning to Walk? Y N
17. Play Childhood Sports? Y N
18. Undergo any Prolonged Use of Medicine such as Antibiotics? Y N
    or an Inhaler? Y N
    Other? Y N
19. Fall / Jump from a Height Over 3 ft? (i.e. Crib, Bunk Bed, Tree) Y N
20. Get Pulled by your Arm? Y N
21. Experience other Traumas? (Physical or Emotional) Y N

Adult Years – (18 To Present)

Did / Do you…

22. Smoke? Y N
23. Drink? Y N
24. Have you been in Accidents? Y N
25. Have you had Surgery? (any Organs Replaced / Removed?) Y N
26. Drugs? (Prescribed or Over-the-Counter) Y N
27. Have Teeth Problems? Y N
28. Have Eye Problems? Y N
29. Have Hearing Problems? Y N
30. Have Hobbies / Sports Injuries? Y N

On a scale of 0 – 10, describe your stress level:
(0 = None / 10 = Extreme)
Occupational _____ Personal _____

On a scale of Poor, Fair, Good, Excellent, describe your:
Diet ______________ Exercise _________________
Sleep ______________ General Health _____________

Sleeping posture (Please circle): Back – Side – Stomach

DOCTOR'S COMMENTS: ____________________________
____
____
____
____
____
____

(Continued on Other Side)

HEALTH & WELLNESS SOLUTIONS FAMILY CHIROPRACTIC, INC.

Addressing The Issues That Brought You To Our Office

Although we do not treat any specific symptom or condition, we realize that symptoms and conditions may arise as a result of nerve interference/subluxations.

If you have no symptoms or complaints, please check here ____ **"Wish to have Chiropractic Wellness Services"** and skip to "***Family History***".

Others may briefly describe the chief area of complaint, including the effect it has had on your life. ______________
____
____

Problem started on__________ Since the problem started, it is: ❒ The Same ❒ Better ❒ Worse
If experiencing pain, please describe: ❒ Sharp ❒ Dull ❒ Constant ❒ Comes and Goes ❒ Travels
What makes the condition worse? ____
What makes the condition better? ____
Is condition worse during certain times of the day? ______________________________________
Is this condition interfering with: Work? ______ Sleep? ______ Routine? ______ Other? ______________
Other Doctors seen for this condition ____

Other Symptoms:

❒ Headaches	❒ Hot Flashes	❒ Light Bothers Eyes	❒ Diarrhea
❒ Neck Pain	❒ Stiff Neck	❒ Loss of Memory	❒ Cold Feet
❒ Sleeping Problems	❒ Pins & Needles in Legs	❒ Ears Ring	❒ Cold Hands
❒ Back Pain	❒ Pins & Needles in Arms	❒ Fever	❒ Upset Stomach
❒ Nervousness	❒ Numbness in Fingers	❒ Fainting	❒ Constipation
❒ Tension	❒ Numbness in Toes	❒ Cold Sweats	❒ Ulcers
❒ Irritability	❒ Shortness of Breath	❒ Loss of Smell/Taste	❒ Loss of Balance
❒ Chest Pains	❒ Fatigue	❒ Menstrual Pain/Irregularity	❒ Buzzing in Ear
❒ Dizziness	❒ Depression		

What medications are you taking? ____
How Long? _______________ *Surgical History:* What? __________________________ When?_______________

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _______________
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

Have You Ever:

Bought bottled water:	❒ YES	❒NO
Belonged to a health club:	❒ YES	❒NO
Consumed vitamins or supplements:	❒ YES	❒NO

Wellness Commitment:

At Health & Wellness Solutions Family Chiropractic, we are fully dedicated toward achieving the goal of optimizing the inborn potential of all our members. To better help us achieve this goal, we need to understand your commitment toward being your best. Based on a scale of 10% to 100%, **please circle** your personal level of commitment toward enhancing your human potential and overall health and wellness.

10%-------- 20% --------30%-------- 40% --------50%-------- 60%--------70%-------- 80%--------90% ------- 100%

As a result of my chiropractic care, I would like to

Please Check All That Apply:

- ❒ Feel better
- ❒ Optimize my overall function and performance
- ❒ Be able to better adapt to stress *(physical, chemical, emotional)*
- ❒ Experience a wider range of perceptions, emotions, and genetic potential

______________________________________ Signature

____________________ Date

HEALTH & WELLNESS SOLUTIONS FAMILY CHIROPRACTIC INC.