Office Use: Date: Patient #:

PATIENT HEALTH HISTORY

Welcome! *Please complete this form and bring it to your first appointment.*

PERSONAL INFORMATION

Name:		Gender: ☐ Female ☐ Male ☐ Other
Date of Birth:	Age:	
Address:	City:	Postal Code:
E-mail:	Mobile #:	Home #:
Occupation:	Employer:	
Marital Status:	Spouse's Name:	Children:

How did you hear about our office? ☐ Website ☐ Internet ☐ Location ☐ Referral:

Have you been to a chiropractor before? ☐ Yes ☐ No

Name of chiropractor:	City:
Date of last visit:	Duration and frequency of care:
Were X-rays taken? ☐ No ☐ Yes	

Do you have extended health benefits that contribute to chiropractic care? ☐ No ☐ Yes

Yearly amount:	Renewal date:

Chiropractic care can be used in three ways.

We provide recommendations based on our findings to help you meet your specific health goals.

Please check which you feel applies to your situation:

☐ *I just want to get rid of my pain, I'm not interested in long term correction.*

☐ *I want to get to the root of the problem and fix it for good!*

☐ *I don't have any major health concerns and I want to keep it that way! I am here for preventive care.*

Do you foresee any barriers that will prevent you from reaching your health goals?

☐ Time ☐ Finances ☐ Other:

Please mark an "X" where you believe your health is and an "O" where you would like it to be:

Disease/ Sickness | Symptoms/ Pain | No Symptoms/ No Pain | 100% Alive/ Healthy

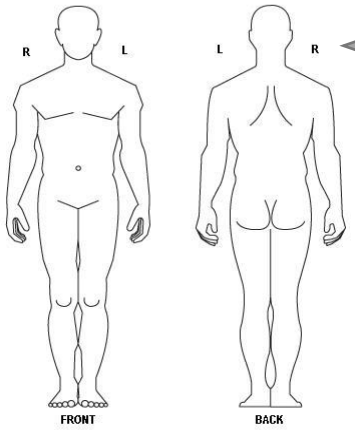
What are your health goals?

HEALTH CONDITIONS

Please list and describe your Health Concerns in order of severity:

Pain Level 1-10, 0 = no pain, 10 = excruciating).
Feels like examples: sharp, dull, throbbing, burning, aching, stabbing, etc.

1st Health Concern:	
When did you first notice it?	What Makes it worse?
How often do you feel it?	
Getting better or worse?	
Pain Level (1-10):	What makes it feel better?
What does it feel like?	
Doctor's notes:	
2nd Health Concern:	
When did you first notice it?	What Makes it worse?
How often do you feel it?	
Getting better or worse?	
Pain Level (1-10):	What makes it feel better?
What does it feel like?	
Doctor's notes:	
Additional Health Concerns	



Please mark the area of your symptoms with an 'X' on the diagram:

Does this affect your work, personal life, mood, or quality of life?
□ No □ Yes - Explain:

Are you pregnant? □ No □ Yes □ Unsure

Have you consulted any other health care providers? □ No □ Yes

If yes, list providers, diagnosis and treatment:

Please list any medications you are currently taking, and the reason:

Please list any surgeries you have had:

Your **nervous system** controls and coordinates all of your body functions. **Chiropractic care** is designed to correct misalignments that inhibit your nervous system, which in turn reduce body function. The following questions will help give us a complete picture of your health.

Please check all conditions that you have experienced or have been diagnosed with (past or present):

☐ Cancer	☐ Difficulty Swallowing	☐ Stomach Pain	☐ Infertility
☐ Unexplained weight loss	☐ Blurry/Double Vision	☐ Bloody Stools/Urine	☐ Diabetes
☐ Chest Pain	☐ Chronic Cough	☐ Constipation/Diarrhea	☐ Allergies
☐ Prev. Heart Attacks	☐ Difficulty Breathing	☐ Bowel Problems	☐ Ringing in ears
☐ Poor Circulation	☐ Thyroid Dysfunction	☐ Incontinence	☐ Depression
☐ Previous Stroke	☐ Fever/Chills/Sweats	☐ Crohn's Disease	☐ Anxiety
☐ High Blood Pressure	☐ Fainting/Convulsions	☐ Colitis	☐ Tremors
☐ Irregular Heartbeat	☐ Spitting Blood	☐ Painful Urination	<u>Women Only</u>
☐ High Cholesterol	☐ Nausea or Vomiting	☐ Waking to Urinate	☐ Painful cycles
☐ Slurred Speech	☐ Hernia	☐ Arthritis	☐ Irregular cycles

Please check all other conditions that you have experienced recently:

☐ Headaches	☐ Elbow Pain	☐ Low Energy	☐ Frequent Colds/Flu
☐ Neck Pain	☐ Shoulder Pain	☐ Irritable/Nervousness	☐ Heartburn
☐ Mid Back Pain	☐ Knee Pain	☐ Skin Problems	☐ Poor Digestion
☐ Low Back Pain	☐ Wrist Pain	☐ Dizziness	☐ Sleeping Difficulty
☐ Leg Pain/Tingling	☐ Ankle/Foot Pain	☐ Ringing in Ears	☐ Poor Memory

Even minor impacts can result in misalignment in your spinal column *whether you were hurt or not.*

Please describe all traumas, accidents or falls:

Car accidents:

Falls/ other trauma:

Please list any important family history:

Activities of our daily life, poor posture and repetitive tasks have lasting effects on the nervous system.

Please list any jobs/hobbies that involve tasks that are physically repetitive in nature:

Do you sit at a desk/computer for more than 3hrs daily: ☐ No ☐ Yes

Please list any sports that you have played regularly/frequently:

Please consent to receiving reminders for appointments and important information related to care at Arc of Life, you may opt out at any time:

Signature: _____ Date: _____