**Office Use:** Date: Patient #:

# PATIENT **HEALTH HISTORY**

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

## PERSONAL INFORMATION

| | | |
|---|---|---|
| Name: | | Age: |
| Address: | City: | Postal Code: |
| Home phone: | Cell phone: | Work phone: |
| E-mail address: | Birth date: | |
| 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?** ☐ No ☐ Yes

| | |
|---|---|
| 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

**What is your primary health concern?**

**Have you consulted any other health care providers?** ☐ No ☐ Yes
If yes, list providers, diagnosis and treatment:

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 | **Women Only** |
| ☐ 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 |
| ☐ Arm Pain/Tingling | ☐ TMJ pain | ☐ Poor Vision | ☐ Poor Concentration |

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

Please list any surgeries you have had:

Misalignments in the nervous system can be caused by many things. Even minor falls or accidents can result in misalignment. **Please briefly describe all traumas, accidents or falls, *whether you were hurt or not.***

Car accidents:

Falls/ other trauma:

The activities of our daily life, poor posture and repetitive tasks have lasting effects on the nervous system. **Please list all jobs/activities that you have engaged in frequently, *even those from childhood.***

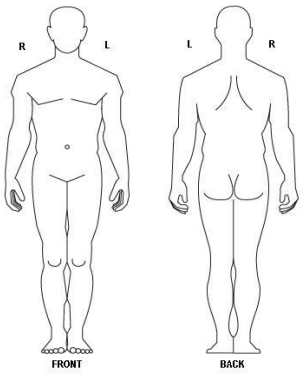
Do you sit at a desk/computer for more than 3hrs daily: □ No □ Yes

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

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

**Please list your primary health concerns in order of severity (intensity** of 1-10, 0 = no pain, 10 = excruciating). **Type of pain** examples: sharp, dull, throbbing, burning, aching, stabbing, etc.

| 1st Problem | |
|---|---|
| Onset | Aggravating factors |
| Frequency (e.g. "daily") | |
| Getting better or worse? | |
| Intensity | Relieving factors |
| Type of pain | |
| Doctor's notes: | |
| 2nd Problem | |
| Onset | Aggravating factors |
| Frequency | |
| Getting better or worse? | |
| Intensity | Relieving factors |
| Type of pain | |
| Doctor's notes: | |
| **Additional Health Concerns** | |




**Please indicate the location of your symptoms with an 'X' on the diagram.**

**Do your health concerns affect your work, personal life, mood, or quality of life?** □ No □ Yes

Explain:

**Are you pregnant?** □ No □ Yes □ Unsure

I, _____, give consent to receiving email reminders for my chiropractic appointments and new patient curriculum.

Signature: _____ Date: _____

Patient: Date:

arc of life CHIROPRACTIC

# NEW MOM **HEALTH HISTORY**

## PRE-PREGNANCY

**How many prior pregnancies have you had?**

Briefly describe all previous pregnancies and deliveries:

**Were there any difficulties getting pregnant?**
Explain:

**How was your general health prior to your pregnancy?**

## PREGNANCY

| | | | |
|---|---|---|---|
| **During pregnancy, did you …** | | Smoke? ☐ Yes ☐ No | Drink alcohol? ☐ Yes ☐ No |
| Take supplements? | ☐ Yes ☐ No | Type: | |
| Have an illness? | ☐ Yes ☐ No | Type: | |
| Take drugs? | ☐ Yes ☐ No | Type: | |
| Have an ultrasound? | ☐ Yes ☐ No | How many and medical reason: | |
| Have an invasive procedure? (Amniocentesis, CVS) | ☐ Yes ☐ No | Type: | |
| Take antibiotics? | ☐ Yes ☐ No | Type: | Number of courses: |
| Have a vaccination? | ☐ Yes ☐ No | Type: | Reaction: |
| Have pets at home? | ☐ Yes ☐ No | Type: | |
| Have smokers at home? | ☐ Yes ☐ No | | |

**Any trauma during pregnancy?** (Falls, accidents, etc.)

Did you experience any pain or discomfort during your pregnancy?

Any hospitalizations and/or surgeries?

**Were there any known complications during pregnancy?**

**Did you experience physical and/or emotional stress during pregnancy?** (This includes carrying other children, repetitive motions at work, emotional stress, etc.) ☐ Yes ☐ No

Explain:

## BIRTH

| | | | | |
|---|---|---|---|---|
| Duration of gestation: | | Duration of birth: | | |
| Location of birth: | | | | |
| **Assisted?** ☐ Yes ☐ No | **If yes:** ☐ forceps | ☐ vacuum extraction | ☐ C-section | ☐ induced labour |
| **Medications delivered to mother at birth?** | | ☐ Yes ☐ No | If yes, what: | |
| **Was the birth normal?** | ☐ Yes ☐ No | | | |
| Complications: | | | | |
| **APGAR?** | At birth: | After 5 min: | | |
| Birth weight: | | Birth length: | | |

Patient: Date:

| POSTNATAL |
| --- |
| **Any difficulty with breastfeeding?** ☐ Yes ☐ No Explain: |
| **How are your sleep patterns?** |
| **Are you experiencing post-partem anxiety and/or depression?** ☐ Yes ☐ No |
| **Any restrictions to your diet?** |
| **Are you experiencing any changes in digestion?** |

| |
| --- |
| **What would you like to gain from chiropractic care?** |
| **Any other concerns we should know about?** |
| **How can we make your experience in our office even better?** |



Patient: Date: