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:	Gender: ☐ Female ☐ Male ☐ Other	
Marital Status:	Employer:	
Children:	Spouse's Name:	

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

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:

Please list any important family history:

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.***

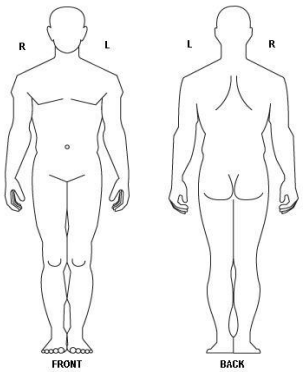
Do you sit at a desk/computer for more than 3hrs daily: ☐ No ☐ Yes

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: _____