ABOUT YOU

Date _____

Name _____ Nick Name _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Date of Birth _____ Soc. Sec. No. _____

Occupation _____ Employer's Name _____

Employer's Address _____ City _____ State _____ Zip _____

Work Phone _____ Cell Phone _____ E-Mail Address _____

Spouse's Name _____ Spouse's Date of Birth _____

Spouse's Soc. Sec. No. _____ Spouse's Occupation _____

Spouse's Employer _____ Spouse's Work Phone _____

Name and Ages of Children _____

_____

PRESENT HEALTH STATUS

Reason for this visit: _____

When did this begin? _____ Has this occurred before? When? _____

Is the condition: (circle one) getting worse getting better the same

Other Doctors seen for this condition: ☐ Yes ☐ No Who? _____

Type of treatment:: _____ Results: _____

What do you believe is wrong with you? _____

What other health problems do you have? _____

_____

_____

PAST HEALTH HISTORY

What accidents, falls, injuries have you had? NOTE: This includes falls, contact sports, etc.? Please include date:

_____

_____

_____

Have you broken any bones? Which ones? How? When? _____

_____

List ALL Surgeries that you have had including dates: _____

_____

Drugs currently taken and reason for use: _____

Previous Chiropractors name and approximate date of last visit: _____

FOR WOMEN

Is there any possibility that you are pregnant? ☐ Yes ☐ No Date of last menstrual period: _____

FOR CHILDREN

Were there any complications during pregnancy or delivery? ☐ Yes ☐ No

Describe: _____

Type of birth (circle all that apply) Natural Cesarean Forceps Suction

HEALTH HABITS

TELL US ABOUT YOUR HEALTH HABITS (Be Honest)

	Very poor									Excellent
How restful is your sleep?	1	2	3	4	5	6	7	8	9	10
How is your diet?	1	2	3	4	5	6	7	8	9	10
How well do you deal with stress?	1	2	3	4	5	6	7	8	9	10
What is your level of exercise?	1	2	3	4	5	6	7	8	9	10
Rate your overall health	1	2	3	4	5	6	7	8	9	10
How much fun do you have?	1	2	3	4	5	6	7	8	9	10

LIFESTYLE

What do you do at work? _____

What kind of sports or other physical activities do yo do? _____

How was your birth? _____

Do you use: (Circle) Tobacco Medications Vitamins Food Supplements

What activities have you had to restrict due to health problems? _____

_____

Does any one else in your family have health problems? _____

_____

How did you hear about our office? _____

In case of emergency, contact: _____

PLEASE DO NOT WRITE BELOW THIS LINE

CONSULTATION