

## Patient History (page 1 of 2)

Name \_\_\_\_\_ Referred by \_\_\_\_\_  
 Date \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_ Occupation \_\_\_\_\_  
 City, State, Zip \_\_\_\_\_ Employer \_\_\_\_\_  
 Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Marital Status    S       M       D       W  
 E-mail \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ (AGE) \_\_\_\_\_ Spouse's Date of Birth \_\_\_\_\_

**CHILDREN**

**PREVIOUS CHIROPRACTIC CARE?**

Name \_\_\_\_\_ Age \_\_\_\_\_  Yes  No Reason \_\_\_\_\_  
 Name \_\_\_\_\_ Age \_\_\_\_\_  Yes  No Reason \_\_\_\_\_  
 Name \_\_\_\_\_ Age \_\_\_\_\_  Yes  No Reason \_\_\_\_\_  
 Name \_\_\_\_\_ Age \_\_\_\_\_  Yes  No Reason \_\_\_\_\_

*You deserve to be healthy. When you were created, your body was given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be challenged by various interferences. Through your examination and involvement in chiropractic care, we will work to remove these interferences so that you can live the quality of life you deserve.*

**CIRCLE ALL THAT APPLY**

**PATIENT    SPOUSE    CHILD 1    CHILD 2    CHILD 3    STAFF COMMENTS**

**Labor and Birth**

Forceps?	Y	Y	Y	Y	Y	_____
Caesarian?	Y	Y	Y	Y	Y	_____
Breach / Cephalic?	Y	Y	Y	Y	Y	_____
Mother given drugs during delivery?	Y	Y	Y	Y	Y	_____
Induced labor?	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____

**Growth and Development**

Have you ever...						
Learned to care for your spine?	Y	Y	Y	Y	Y	_____
Banged your head?	Y	Y	Y	Y	Y	_____
Breast-fed?	Y	Y	Y	Y	Y	_____
Had a serious childhood sickness?	Y	Y	Y	Y	Y	_____
Had any accidents?	Y	Y	Y	Y	Y	_____
Had surgery?	Y	Y	Y	Y	Y	_____
Taken drugs?	Y	Y	Y	Y	Y	_____
Experienced other traumas?	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____

**Current Health Habits**

Did or do you...						
Smoke?	Y	Y	Y	Y	Y	_____
Drink?	Y	Y	Y	Y	Y	_____
Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	_____
Drugs? (Prescriptive or non-prescriptive)	Y	Y	Y	Y	Y	_____
Exercise regularly?	Y	Y	Y	Y	Y	_____
Have sleeping problems?	Y	Y	Y	Y	Y	_____

## Patient History (page 2 of 2)

**CIRCLE ALL THAT APPLY**

	PATIENT	SPOUSE	CHILD 1	CHILD 2	CHILD 3	STAFF COMMENTS
<b>Current Health Habits (continued)</b>						
Have occupational stress?	Y	Y	Y	Y	Y	_____
Have physical stress?	Y	Y	Y	Y	Y	_____
Have mental stress?	Y	Y	Y	Y	Y	_____
Have hobbies / sports injuries?	Y	Y	Y	Y	Y	_____
Other	Y	Y	Y	Y	Y	_____

**Current Health Condition**

Present complaint or reason for your visit today (be brief) \_\_\_\_\_

Pain or Problem started on \_\_\_\_\_ Pain is:  Sharp  Dull  Constant  Intermittent

What activities aggravate your condition/pain? \_\_\_\_\_

What activities lessen your condition/pain? \_\_\_\_\_

Is condition worse during certain times of the day? \_\_\_\_\_

Is this condition interfering with  Work?  Sleep?  Routine?  Other?

Is this condition getting progressively worse? \_\_\_\_\_

Other Doctors seen for this condition \_\_\_\_\_

Any home remedies? \_\_\_\_\_

**Other symptoms**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Neck pain           | <input type="checkbox"/> Sleeping problems  | <input type="checkbox"/> Back pain              |
| <input type="checkbox"/> Nervousness            | <input type="checkbox"/> Tension             | <input type="checkbox"/> Irritability       | <input type="checkbox"/> Chest pains            |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Face flushed        | <input type="checkbox"/> Neck stiff         | <input type="checkbox"/> Pins & needles in legs |
| <input type="checkbox"/> Pins & needles in arms | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes   | <input type="checkbox"/> Shortness of breath    |
| <input type="checkbox"/> Fatigue                | <input type="checkbox"/> Depression          | <input type="checkbox"/> Light bothers eyes | <input type="checkbox"/> Loss of memory         |
| <input type="checkbox"/> Ears ring              | <input type="checkbox"/> Fever               | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Buzzing in ear         |
| <input type="checkbox"/> Loss of smell          | <input type="checkbox"/> Loss of taste       | <input type="checkbox"/> Diarrhea           | <input type="checkbox"/> Feet cold              |
| <input type="checkbox"/> Hands cold             | <input type="checkbox"/> Stomach upset       | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Loss of balance        |
| <input type="checkbox"/> Other _____            |  |   |   |

Have you been under drug and medical care? \_\_\_\_\_

What medications are you taking? \_\_\_\_\_ How Long? \_\_\_\_\_

Have you had surgery?  Yes  No What? \_\_\_\_\_ When? \_\_\_\_\_

What side effects have you experienced from the drugs and surgery? \_\_\_\_\_

HAS THERE BEEN A HISTORY OF	HEART DISEASE	ARTHRITIS	CANCER	DIABETES	OTHER
Mother's Side	Y	Y	Y	Y	_____
Fathers Side	Y	Y	Y	Y	_____

**As a result of my chiropractic care, I would like to (check all that apply)**

- |   |   |
|---|---|
| <input type="checkbox"/> Feel better quickly                                      | <input type="checkbox"/> Have a healthier spine     |
| <input type="checkbox"/> Have a healthier body by keeping my nerve system healthy | <input type="checkbox"/> Live a healthier lifestyle |

I attest that all of the above information is correct to the best of my knowledge.

\_\_\_\_\_ patient signature \_\_\_\_\_ date



## Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. Each patient must understand both the objective and the method that will be used to attain it.

**ADJUSTMENT** *The adjustment is the specific application of forces that facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.*

**VERTEBRAL SUBLUXATION** *A misalignment of one or more of the 24 vertebra in the spinal column which causes a decrease in nerve function and alters the transmission of brain impulses. Gone untreated, subluxations result in a lessening of the body's innate ability to achieve its maximum health potential.*

**HEALTH** *The state of physical, mental and social well being, not just the absence of disease or infirmity.*

We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise the patient. If the patient requires specific diagnosis or treatment of those findings, we will recommend that they seek the services of another health care provider who specializes in that area.

Our only objective is to eliminate the interference that hinders the body's innate ability to achieve maximum health. Our method is specific adjusting to correct vertebral subluxations.

I, \_\_\_\_\_ have read and fully understand the above statements.  
(print name)

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

### CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_  
have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive an initial chiropractic examination.