Personal and Family Health History

Name ______________________________________
Today's Date ______________________________
Address ___________________________________
City ____________________ State ____ Zip ________
Phone: (H) _______________ (W) ________________
(C) _______________
Date of Birth ______________________________
Social Security # ___________________________

Occupation ___________________________________
Employer ____________________________________
Marital Status S M D W
Spouse's Name _______________________________
Spouse's Occupation ___________________________
Spouse's Cell # ________________________________
Nearest Relative's Phone #______________________
Email address ________________________________

Current Health Habits:

Did/do you:

Smoke............................	Y N	Amount _____________	Frequency _____________	
Drink Alcohol..................	Y N	Amount _____________	Frequency _____________	
Drink Water …………….	Y N	Amount _____________	Frequency _____________	
Diet /Eat Healthfully…......	Always	Most of the time	Rarely	Never
Have you been in accidents	Y N	Explain ______________________________		

Complaint or Reason For Your Visit Today:

Primary ____
Pain or Problem started on____
Pains are: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent
What activities aggravate your condition/pain? ___________________________
Is this condition getting progressively worse? ___________________________
Other Doctors seen for this condition ___________________________________

Other symptoms:

❒ Headaches	❒ Face Flushed	❒ Depression	❒ Diarrhea
❒ Neck Pain	❒ Neck Stiff	❒ Light Bothers Eyes	❒ Feet Cold
❒ Sleeping Problems	❒ Pins & Needles in Legs	❒ Loss of Memory	❒ Hands Cold
❒ Back Pain	❒ Pins & Needles in Arms	❒ Ears Ring	❒ Stomach Upset
❒ Nervousness		❒ Fever	❒ Constipation
❒ Tension	❒ Numbness in Fingers	❒ Fainting	❒ Loss of Balance
❒ Irritability	❒ Numbness in Toes	❒ Cold Sweats	❒ Buzzing in Ear
❒ Chest Pains	❒ Shortness of Breath	❒ Loss of Smell	
❒ Dizziness	❒ Fatigue	❒ Loss of Taste	

Are you currently under the care of a physician? __________

If so, for what reason(s)? ____.

Are you currently taking any prescription medications? _________ If so, please list: ______________________
____.
Have you had any surgeries? _________ If so, for what? (Please list dates):
____.

Please check family history

	Heart Disease	Arthritis	Cancer	Diabetes	Other (Please Describe)
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

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

❒ Feel better quickly
❒ Have a healthier spine
❒ Have a healthier body by keeping my nerve system healthy
❒ Live a healthier lifestyle

Upon the completion of this initial visit, a meeting time will be set up for a Chiropractic Report of Facts to discuss my specific health care needs. I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. Should my account be referred for outside collection, I agree to pay all collection costs, attorney fees, and court costs.

______________________________ Signature

______________ Date