Health History

NAME _____ BIRTHDATE (M/D/Y) _____ AGE _____ SEX M / F

ADDRESS _____ CITY _____ POSTAL CODE _____

PHONE HOME _____ WORK _____ CELL _____

EMAIL _____ CARE CARD _____

OCCUPATION_____ EMPLOYER _____

SPOUSE/PARTNER'S NAME _____

CHILDREN'S NAME & AGE _____

WHO REFERRED YOU TO US? _____

HAVE YOU HAD CHIROPRACTIC CARE IN THE PAST? Y / N WHEN? _____

WHY?_____ WITH WHOM?_____

RECENT MEDICAL CARE? Y / N. IF YES, WHY? _____

CURRENT DRUGS/MEDICATION _____

REASON FOR CONSULTING THIS OFFICE _____

_____

PLEASE CHECK THE CHOICE THAT MOST CLOSELY DESCRIBES
YOUR CURRENT GOALS FOR HEALTH/WELLBEING

- o I am only concerned about relief of a particular symptom.
- o I am only concerned about relief of a particular symptom, and preventing its return.
- o I want optimum health and wellbeing on every level available to me.

PERSONAL HEALTH

The human body is designed to express health and function normally. However, events may occur in life, which can interfere with this natural ability.

This interference is most commonly the result of vertebral subluxations.

Stress can be physical, chemical or emotional and may cause these subluxations.

The practice of Chiropractic is based on the location and reduction of nerve system interference caused by the vertebral subluxation.

Please check any that apply

PLEASE TELL US ABOUT ANY STRESS AT YOUR BIRTH

Drugs/medicine/tobacco/alcohol in pregnancy — Explain _____
Labor chemically induced? _____
Forceps/Vacuum Extraction/C-section _____
Premature delivery? _____
Vaccinations? _____
Falls in first year of life? _____
Any health related problems? _____

PLEASE TELL US ABOUT ANY STRESS ASSOCIATED WITH CHILDHOOD:

Any falls or injuries? — Explain _____
Allergy/Asthma or Respiratory Problems? _____
Ear infections? _____
Digestive problems? _____
Hyperactivity? _____
Any other health related problems? _____

PLEASE TELL US ABOUT ANY STRESSES UP TO PRESENT:

Auto Accident or Work Injury? — Explain _____
Injury? or Sports Injury? _____
Family/Home Stress? _____
Prescriptive Drug Use? _____
Non-Prescription drug Use? _____
Ever Hospitalized? _____
Surgery? _____
Any Major Illness? _____
Reoccurring Illnesses? _____
Limited Exercise? _____
Poor Nutrition? _____
Addictions? _____
Anxiety/Depression/Fatigue? _____

Are you pregnant? Please check one. □**Yes #** of Weeks ___ □**No** □**Maybe**

Anything else? _____

Patient Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including X-rays if necessary, on me by the Doctor(s) of Chiropractic affiliated with me. I have had an opportunity to discuss with the doctor(s) of chiropractic, adjustments and other procedures. Although I am expected to get great benefit from chiropractic care, I understand that the results are not guaranteed. I further understand and am informed that as in all health care, with certain chiropractic techniques, there are some very slight risks to treatment, including, but not limited to, muscle strains, and sprains, disc injuries and rib fractures. The possibility of an associated stroke with an upper cervical adjustment is extremely remote and un-established.

I do not expect the doctor to be able to anticipate all the risks and complications. I rely on the doctor's exercise of judgment which chiropractic procedure, based upon the facts known, is in my best interest. I have read this consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend this consent form to cover the entire course of current and future chiropractic care for which I seek treatment.

I understand that I am responsible for payment of all services and that they are to be paid in full at time service is rendered, unless prior arrangements have been made.

Patient's Signature:_____ Date: _____

Guardian's Signature: _____ Date: _____