HEALTH HISTORY

Name_____ Date_____

Address_____

City, Zip_____ (H) Phone_____

Email_____ (W or C) Phone_____

How do you want appointment reminders sent to you? ☐ Email ☐ Txt

If Txt what cell carrier do you use? (important)_____

Please tell us how you heard about us?_____

Job Position_____ D.O.B._____ Sex_____ Number of Children_____

Marital Status □ Single □ Partner □ Married □ Separated □ Divorced □ Widow(er)

Are you recovering from a cold or flu?_____ Are you pregnant? ☐Y ☐N

Reason for office visit:

1_____ Date condition began_____

2_____ Date condition began_____

3_____ Date condition began_____

List any health problems you are currently being treated:

_____

_____

_____

What types of therapies have you tried for these problems or to improve your health overall:

□ diet □ fasting □ vitamin/minerals □ herbs □ homeopathy □ chiropractic □ acupuncture □ conventional drugs

□ other_____

Do you experience any of these general symptoms EVERY DAY?

□ Panic attacks	□ Shortness of breath	□ Insomnia	□ Constipation	□ Chronic pain/Inflammation	□ Bleeding
□ Depression	□ Debilitating fatigue	□ Nausea	□ Fecal Incontinence	□ Poor wound healing	□ Discharge
□ Dizziness	□ Disinterest in sex	□ Vomiting	□ Urinary Incontinence	□ Low grade fever	□Itching/rash

Laboratory procedures performed (blood, stool, urine, etc.)_____

Outcome_____

_____

Major Hospitalizations, Surgeries, Injuries. Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Identify the major causes of stress (eg, work, finances, relationship(s), etc)_____

What is your overall energy level on a scale of 1 to 10 (1 being the lowest): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Do you fall asleep easily? ☐Y ☐N Do you sleep through the night? ☐Y ☐N Do you wake rested? ☐Y ☐N

Do you consider yourself: □ underweight □ overweight □ just right

Your weight today_____lbs Your weight at age 20_____lbs Your ideal weight_____lbs

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? ☐Y ☐N

How committed are you to making a change in your health (1 = least, 10 = most committed): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Do you tend to be sensitive to medications? □ Yes □ No

HEALTH HISTORY continued

Current medications (prescriptions or over-the-counter):

List any known allergies:

List any known drug allergies:

Check all that Apply

□ Arthritis
□ Allergies/hay fever
□ Asthma
□ Alcoholism
□ Alzheimer's disease
□ Anxiety
□ Autoimmune disease
□ Blood pressure problems
□ Bronchitis
□ Cancer
□ Chronic fatigue syndrome
□ Carpal tunnel syndrome
□ Chest pain
□ Cholesterol, elevated
□ Circulatory problems
□ Dental problems
□ Depression
□ Diabetes
□ Diverticular disease
□ Drug addiction
□ Eating disorder
□ Epilepsy/seizures
□ Emphysema
□ Eyes, ears, nose, throat problems
□ Environmental sensitivities
□ Fibromyalgia
□ Food intolerance
□ Gastroesophageal reflux disease
□ Genetic disorder
□ Glaucoma
□ Gout
□ Heart disease
□ Infection, chronic
□ IBD/colitis
□ Irritable bowel syndrome
□ Kidney or bladder disease
□ Liver or gallbladder disease (stones)
□ Mental illness
□ Migraine headaches
□ Neurological problems (Parkinson's, paralysis, etc)
□ Stroke
□ Thyroid problems
□ Obesity
□ Osteoporosis
□ Pneumonia
□ Sexually transmitted disease
□ Skin problems
□ Tuberculosis
□ Ulcer
□ Urinary tract infection
□ Varicose veins
Other _____

Medical (Women)

□ Menstrual irregularities
□ Endometriosis
□ Infertility
□ Fibrocystic breasts
□ Fibroid/ovarian cysts
□ PMS (premenstrual syndrome)
□ Breast cancer
□ Pelvic inflammatory disease
□ Vaginal infections
□ Decreased sex drive
□ Menopause
□ Surgical Menopause
□ C-section. How many____
PAP □ + □ –
Mammogram □ + □ –
Number of pregnancies_____
Number of children_____
Age of first period_____
Date of last period_____
Length of cycle____days
Any recent changes in menstrual flow(eg. Heavier, more clots, etc)

_____

Medical (Men)

□ Benign prostatic hyperplasia
□ Prostate cancer
□ Decreased sex drive
□ Infertility

Family Health History (Parents and Siblings)

□ Arthritis
□ Asthma/lung disease
□ Alcoholism
□ Alzheimer's disease
□ Autoimmune disease
□ Cancer
□ Depression
□ Diabetes
□ Drug addiction
□ Eating disorder
□ Genetic disorder
□ Glaucoma
□ Heart disease
□ Hypertension
□ Infertility
□ Mental illness
□ Migraine Headaches
□ Obesity
□ Osteoporosis
□ Stroke
Other_____

Health Habits

□ Smoke
□ Use alcohol
□ Caffeine (coffee, pop, etc)
Glasses of water/day_____
_____
Hours of sleep/night_____
_____
Number of stools/day_____
_____
Consistency of stools:
□ Hard □ Soft □ Marbles
□ Normal □ Other

Exercise

□ none
□ 1 to 2 days per week
□ 3 to 4 days per week
□ 5 to 7 days per week
□ Less than 45 minutes per workout
□ More than 45 minutes per workout

Nutrition & Diet

□ Mixed food diet (animal and vegetable sources)
□ Vegetarian
□ Vegan

Eating Habits

□ One meal per day
□ Two meals per day
□ Three meals per day
□ Graze (small frequent meals)
□ Eat constantly whether hungry or not

I Would Like To:

□ Feel more vital
□ Feel less pain
□ Lose weight
□ Improve memory
□ Be less indecisive
□ Increase sex drive
□ Use less medications
□ Have more endurance
□ Sleep better
□ Be stronger
□ Be less moody
□ Feel more motivated
□ Increase muscle tone
□ Slow down aging

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INFORMED CONSENT

PATIENT NAME _____

Chiropractic Care:
I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as " Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process..

There are certain, rare complications that can occur as a result of a spinal manipulation. These compilations include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, strains and dislocations, costovertebral strains and separation. Extremely rare complications include, but are not limited to stroke or fracture. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

Massage:
I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any discomfort, I will immediately inform the therapist so that the pressure can be adjusted to my level of comfort. I agree to keep the therapist updated to any changes in my health and understand that there shall be no liability on the therapist's part if I fail to do so.

Naturopathic Care:
I understand that all injection treatments are accompanied by possible risks. Risks include bruising, temporary increase in pain, inflammation, infection, allergic reaction, numbness, weakness or paralysis, spinal headache, lung puncture or death as a result of, or in relation to the injections.

Injections may include nerve blocks, Intravenous therapies, trigger blocks, intramuscular injections, scar therapy, joint/tendon/ligament injections, or prolotherapy.

I understand that insurance reimbursement for injections varies and that prolotherapy may be considered investigational or experimental by some carriers or Medicare.

I am aware of all of the above mentioned complications for each therapy I may receive, and in order to minimize their occurrence I will take precautions. I have been given the opportunity to discuss the nature and purpose of all treatments in this office, alternative methods of treatment, risks and complications associated with them. I acknowledge that all my questions have been answered to my satisfaction and that I have been further told that any additional questions I may have will be answered.

If my child is a minor, I have given consent for him/her to receive the necessary care in this clinic according to this consent.

DATE _____

_____
Printed Name

_____
Signature

_____
Signature of Parent or Guardian (if a minor)