CHIROPRACTIC
HEALTH HISTORY FORM

(Please answer all questions even if they seem unrelated to your case)

Name: _____ Date: _____
Phone # (H) _____ (W) _____ (C) _____
(Check your preferred phone number above)

Address: _____Postal Code_____
Birth Date : _____Age: _____Wt: _____Ht:_____ # of Children _____
(dd / mm / yy)
Sex: ☐ Male ☐ Female Marital Status: _____Family MD _____

Occupation: _____Employer:_____
E-Mail Address: _____ Past Chiropractic Care _____ YES _____ NO

How did you find out about us?

☐ Healthcare Provider ☐ Lawyer ☐ Employer ☐ Website ☐ Family/ Friends
☐ Here Before ☐ Yellow Pages
Who referred you ? _____

Present Complaint: _____
When did this condition begin? _____
What caused this condition _____
Please rate the severity of your pain from 0 – 10, with 10 being the worst pain _____
Are there others in your family with this condition? _____
Is this work related? ☐ due to a motor vehicle accident? ☐ Date of injury/ accident _____

Please complete the following chart: (including frequency of use)

Prescription Medication	Over the Counter Medication	Vitamins & Supplements

Have you been treated for any health conditions in the last year? ☐ YES ☐ NO If yes, list any upcoming /recent tests or surgeries. _____
_____

How important is your health to you on a scale of 1 – 10, 10 being the most important_____

Provide dates of **ALL** surgeries, fractures and major illnesses: _____
_____
_____
_____

List **ALL** motor vehicle accident dates and other major accidents or falls: (Please Describe) _____
_____
_____

Please √ and list any of the following devices that you currently wear or are implanted:

- ☐ Prosthetic devices_____ ☐ Hearing aids ☐ Orthotics
- ☐ Metal implants _____ ☐ Pacemaker ☐ Heel lifts/inserts

Check √ any conditions which are **presently** causing you a problem. Please underline conditions which **were** a problem in the past.

GENERAL
- ☐ headache
- ☐ migraines
- ☐ dizziness
- ☐ ringing in ears
- ☐ fainting
- ☐ earache
- ☐ sore throat
- ☐ nose bleeds
- ☐ sinus problems
- ☐ asthma
- ☐ enlarged glands
- ☐ unexplained weight loss
- ☐ hypoglycemia
- ☐ nervousness/anxiety
- ☐ depression/confusion`
- ☐ vision problems
- ☐ dental problems
- ☐ hearing problems
- ☐ fever
- ☐ night sweats

ORGANS
- ☐ frequent urination
- ☐ painful urination
- ☐ blood in urine
- ☐ bladder problems
- ☐ kidney stones
- ☐ bed wetting
- ☐ prostate problems
- ☐ sexual dysfunction
- ☐ anemia
- ☐ eating disorders
- ☐ thyroid problems
- ☐ excessive appetite `
- ☐ gas/ bloating
- ☐ nausea/vomiting `
- ☐ constipation/diarrhea
- ☐ colitis
- ☐ black/ bloody stool
- ☐ hemorrhoids
- ☐ liver problems
- ☐ gall bladder
- ☐ rheumatic fever

SKIN
- ☐ eczema
- ☐ skin eruptions
- ☐ varicose veins
- ☐ rashes
- ☐ loss of sensation

MUSCLE & JOINT
- ☐ neck problems
- ☐ whiplash
- ☐ upper back problems
- ☐ low back problems
- ☐ tailbone pain
- ☐ spinal curvature
- ☐ pelvic numbness/or pins and needles
- ☐ limb problems
- ☐ walking problems
- ☐ arthritis
- ☐ rheumatoid arthritis
- ☐ sore joints
- ☐ sore muscles
- ☐ jaw problems

RESPIRATORY & HEART
- ☐ lung problems
- ☐ chronic cough
- ☐ spitting up blood
- ☐ frequent colds/flu
- ☐ difficulty breathing
- ☐ heart problems
- ☐ swollen ankles

FEMALES ONLY
- ☐ painful periods
- ☐ irregular cycle
- ☐ cramps, backache
- ☐ vaginal discharge/infection
- ☐ lumps/pain in breast
- ☐ menopausal symptoms
- ☐ previous miscarriage
- ☐ hot flashes
- ☐ Are you pregnant?
- ☐ YES ☐ NO ☐ Not Sure
- ☐ When is your due Date? _____
_____

Check any of the following diseases you have (or have had)

- ☐ alcoholism ☐ HIV ☐ hepatitis ☐ epilepsy ☐ stroke ☐ arthritis ☐ heart disease
- ☐ sexually transmitted diseases ☐ diabetes ☐ cancer ☐ allergies ☐ Other _____
- ☐ aneurysm ☐ osteoporosis

Has anyone in your family had any of the following diseases?

☐ Heart disease	☐ high blood pressure	☐ cancer	☐ stroke	☐ arthritis	☐ diabetes
Who _____	who _____	who_____	who _____	who _____	who _____

LIFESTYLE	None	Light	Moderate	Heavy		None	Light	Moderate	Heavy
Exercise	☐	☐	☐	☐	Tobacco	☐	☐	☐	☐
Coffee/Tea	☐	☐	☐	☐	Alcohol	☐	☐	☐	☐
Pop	☐	☐	☐	☐	Junk Food	☐	☐	☐	☐
					Stress	☐	☐	☐	☐

Please rate your sleep, hours per night ☐ 4 - 6 hrs ☐ 6 – 8 hrs ☐ 8 – 10 hrs ☐ 10 hrs +

Informed Consent to Chiropractic Treatment

Doctors of chiropractic who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

A) While rare, some patients may experience short term aggravation of symptoms, rib fractures or muscles and ligaments strains or sprains following spinal adjustments.

B) There are reported cases of stroke associated with many common neck movements including adjustments of the upper cervical spine. Present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Furthermore, the apparent association is noted very infrequently. However, you are being warned of the possible association because stroke sometimes causes serious neurological impairment, and may on rare occasion result in injuries including paralysis. The possibility of such injuries resulting from upper cervical spinal adjustment is extremely remote.

C) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustment although no scientific study has ever demonstrated such injuries are caused, or may be caused by spinal adjustments or chiropractic treatment.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic is substantially lower than that associated with many medical or other treatments, medication, and procedures given for the same symptoms.

I acknowledge I have discussed, or have had the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal adjustment) as well as the contents of this consent.

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Dated this _____day of _____, 20 _____

Patient Signature (Legal Guardian) Name (Please print)

Witness of Signature Name (Please print)