

Welcome to Natural Health Family Chiropractic. We are honored that you have chosen us to be a part of your health and wellness team. In order to initiate the process of becoming well, we must start by pinpointing the cause of what is keeping you from living to your maximum potential. A short but detailed history is contained on the following pages that will give us a picture of the accumulation of physical, chemical, and emotional stress from childhood until today. All of the following is confidential and we ask that you answer the following questions completely and leave no questions unanswered. Thank you and we look forward to serving you.

Your Personal Information

Name: _____ Date of Birth: _____ Age: _____ Sex: M F
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ SS#: _____
E-Mail Address: _____
Employer: _____ Work Phone: _____
What is the best method to contact you? Home phone Cell phone Work Phone Email
Marital Status: M S W D Spouse's Name: _____
In Case of Emergency Notify: _____ Phone: _____
Who is your family physician? _____
By whom were you referred to this office? _____

Your Current Health Complaint

Please describe the specific complaints that bring you to the office today: _____

When did this start? _____
What do you believe may have caused it? _____
What other doctors have you seen for this condition? _____
Are you interested in Chiropractic Wellness Care? Yes No

Your Past Health Complaints

Early Years (Birth to age 17)

Did you have any severe or abnormal childhood illnesses? Yes No
*If yes, please describe: _____
Did you have any serious traumas as a child (serious falls, car accidents, emotional trauma, birth trauma, etc.)? Yes No
*If yes, please describe: _____
As a child, did you require frequent medication, antibiotics, or use of an inhaler? Yes No
Were you vaccinated as a child? Yes No
As a child, were you under regular chiropractic care? Yes No

Adult Years (Age 18 to present)

Have you ever or are you presently experiencing any serious health conditions? (Please check other and list if not listed)

Allergies Arthritis Asthma Blood disorders Cancer Dementia Depression Diabetes
 Epilepsy Gall bladder disease Heart disease High blood pressure Major infection Kidney disease
 Liver disease Multiple sclerosis Stroke Thyroid disease Other _____

Have you had any **major injuries** as an adult? (Sport injury, work injury, car accident, broken bone, head injury, falls, etc.)

Yes No If yes, please describe these injuries: _____

Have you had any **surgeries** as a child or as an adult?

Yes No If yes, please list surgical procedures: _____

Do you have any **allergies or sensitivities** that you are aware of? (Please check other and list if not listed)

- None Animals Corn Dairy Dust Eggs Fish Gluten Insect stings Latex
 Food additives Legumes Mold Nuts Penicillin Pollen Seafood Seasonal allergies
 Sesame Soy Sulfa drugs Wheat Other _____

Have you **recently or are you presently** taking any **prescription/over the counter medication OR nutritional supplements**?
*We can photocopy an existing list or you may attach a sheet of paper if you are taking many medications or supplements.

Yes No If yes, please list them and reason for taking them: _____

Review of Systems:

Do you presently or have you in the last three (3) months experienced any of the following? Please check all that apply.

- | | | | | |
|---|--|---|--|--|
| <input type="checkbox"/> Chills | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Changes in hair, skin, or nail growth/texture | |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Frequently sick | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Tingling | <input type="checkbox"/> Fainting | <input type="checkbox"/> Weakness | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Memory loss | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Psychiatric problems | <input type="checkbox"/> Irritability | <input type="checkbox"/> Difficult concentrating |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Frequent cough | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Leg pain |
| <input type="checkbox"/> Bruise or bleed easily | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Lymph node enlarged | <input type="checkbox"/> Lymph node tender |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Change in smell/taste | <input type="checkbox"/> Ringing/buzzing in ears | <input type="checkbox"/> Light sensitivity | <input type="checkbox"/> Changes in vision |
| <input type="checkbox"/> Sinus/nasal problems | <input type="checkbox"/> Hot/cold intolerance | <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Joint stiffness/pain |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Back pain/stiffness | <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Unexplained weight changes | | <input type="checkbox"/> Loss of balance/coordination | | |

Females Only: Have you ever or are you presently experiencing any of the following?

- Breast lumps/pain Painful/irregular cycles Infertility Difficult pregnancy/delivery

Your Social Health Profile

How would you grade your overall health? Poor Adequate Good Excellent

How often do you use tobacco? Never Quit Daily Weekly Monthly

How often do you drink alcohol? Never Quit Socially Daily Weekly Monthly

How often do you use illicit drugs? Never Quit Daily Weekly Monthly

How often do you exercise? Never 1-2 days/week 3-4 days/week 5-7 days/week

How would you describe your diet? Poor Adequate Good Excellent

How would you describe your sleep quality? Poor Adequate Good Excellent

What position do you normally sleep in? Back Stomach Left side Right side

How many pillows do you sleep with under your neck? _____

What type of mattress do you sleep on? Innerspring Air Pillow top Foam Other _____

What type of pillow do you sleep on? Down Feather Foam Contour Other _____

How would you describe your daily stress levels? None Mild Moderate Excessive

What is your occupation? _____

Please describe your work activities: _____

Please list any athletic participation or hobbies: _____

Your Family Health Profile

We are interested in the health of your family not only because it is important to your own health history but because we are concerned about their health and well being as well. Do any members of your family (including parents, grandparents, siblings, spouse, and children) have a history of any of the following conditions?

- Allergies Arthritis Asthma Blood disorders Cancer Dementia Depression Diabetes
 Epilepsy Gall bladder disease Heart disease High blood pressure Major infection Kidney disease
 Liver disease Multiple sclerosis History of similar symptoms Sexually Transmitted Disease Stroke
 Thyroid disease Other _____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

Signature

Date