Chiropractic Confidential Health History

Today's Date _____

Name _____ Name I prefer _____
First Mi Last Mr. Mrs. Ms.

Social Security # _____

Mailing Address _____ Street Address _____

City _____ State _____ Zip _____

Email Address _____ Date of Birth _____ Age _____

Home Phone _____ Business Phone _____ Cell Phone _____

Please indicate the best number to contact you: ☐ Home ☐ Business ☐ Cell ☐ Other _____

Employer _____ Type of Work _____

Work Address _____ City _____ State ____ Zip _____

Marital Status: ☐ Married ☐ Domestic Partner ☐ Significant Other ☐ Single ☐ Widowed ☐ Divorced

Name of Spouse/Partner _____ Do you have children? Y / N How Many _____

Spouse/Partner's Employer _____ Type of Work _____

Work Address _____ Work Phone _____

Whom may we Thank for referring you? _____

Have you experienced chiropractic care before? Y / N

When was your last chiropractic adjustment?_____

Chiropractor's Name _____ Did they adjust your spine? Y / N

What is your understanding of chiropratic?_____

What do you hope to receive from this office? _____

Check the word(s) or phrase(s) that most represents your reason for seeking Chiropractic service:

☐ Symptom Relief ☐ Feel Good ☐ Preventive Care ☐ Wellness Care ☐ Optimum Life Potential

Please list below the details of any symptoms you may be experiencing:

PRIMARY COMPLAINT _____

When did this complaint begin?_____

How did this complaint begin?_____

Please describe this condition when it is at its worst: _____

_____

Level of Pain: (low) 1 2 3 4 5 6 7 8 9 10 (Worst) **Frequency:** 25% 50% 75% 100% of awake time

SECOND COMPLAINT _____

When did this complaint begin?_____

How did this complaint begin?_____

Please describe this condition when it is at its worst: _____

_____

Level of Pain: (low) 1 2 3 4 5 6 7 8 9 10 (Worst) F**requency:** 25% 50% 75% 100% of awake time

THIRD COMPLAINT _____

When did this complaint begin?_____

How did this complaint begin?_____

Please describe this condition when it is at its worst: _____

_____

Level of Pain: (low) 1 2 3 4 5 6 7 8 9 10 (Worst) **Frequency:** 25% 50% 75% 100% of awake time

Primary Care Physician _____

Surgeries/Conditions: Please list major surgeries, broken bones or conditions and include dates:

_____

Medications: Please list prescription & over-the-counter medications you are currently taking & their purpose: _____

Any other health related concerns/challenges?_____

Does your condition interfere with daily activities (work, sleep, family, recreation)?

_____

You are the expert of living in your body; what do you think is going on and what do you think your body is telling you?_____

Stress History (Physical, Chemical, Emotional)

Physical

How do you grade your physical health? Low 1 2 3 4 5 6 7 8 9 10 High

Do you Exercise? Y / N What do you do & how often? _____

Please briefly list major accidents, falls, injuries during your life (with approximate date or age you were when it happened):_____

_____

Do you know the history of your birth? ☐ Natural/vaginal ☐ Forceps ☐ Vacuum extraction ☐ Unknown

What physical stresses do you encounter at work? (ie lifting, computing, repetitive motion, prolonged sitting, etc) _____

Chemical

How do you grade your diet/nutrition? Low 1 2 3 4 5 6 7 8 9 10 High

Tobacco use: ☐ Currently ☐ Formerly ☐ Never Type: ☐ Cigarettes ☐ Chewing ☐ Cigar/Pipe

Number of years used: _____

Recreational drug use: ☐ Currently ☐ Formerly ☐ Never Type: ☐ Marijuana ☐ Other: _____

Alcohol use: ☐ Yes ☐ No ☐ Formerly Year quit: _____

Caffeine use: ☐ Yes ☐ No Amount daily: _____

Mental/Emotional

How would you grade your mental/emotional health? Low 1 2 3 4 5 6 7 8 9 10 High

What is the number 1 priority in your life? _____

What do you feel is your number 1 stress? _____

Is there some aspect of your life that brings you joy, inspires you, or helps you feel better about yourself?_____

Family relationship (i.e. good, stressful, none) _____

What are your play & relaxation activities?_____

Family History: Please List Only Mother, Father, Brothers and Sisters

☐ I was Adopted

Family Member	Diagnosis	Age Onset or Age Death	Comments
Mother			
Father			
Brother			
Sister			

Health Conditions:

Please check each of the diseases or conditions that your body is expressing or has expressed in the past. While they may seem unrelated to the purpose of the appointment, they can affect the overall assessment, care plan, and the possibility of being accepted for care.

- ☐ Headaches/Migraines
- ☐ Blurred Vision
- ☐ Tinnitus
- ☐ Dizziness
- ☐ High/Low Blood Pressure
- ☐ Allergies
- ☐ Balance Issues
- ☐ Vertigo
- ☐ Fatigue
- ☐ Insomnia
- ☐ Chest Pain
- ☐ Heartburn
- ☐ Acid Reflux
- ☐ Ulcers
- ☐ Shortness of Breath
- ☐ Carpal Tunnel Syndrome
- ☐ Numbness or Pain in Arms/Hands
- ☐ Numbness or Pain in Legs/ Feet
- ☐ Thyroid Problems
- ☐ Infertility
- ☐ Diarrhea
- ☐ Constipation
- ☐ Excess Gas
- ☐ Hemorrhoids
- ☐ Frequent Urination
- ☐ Dysmenorrhea
- ☐ Foot Problems
- ☐ Prostate Problems
- ☐ Sinus Problems
- ☐ Pain between the shoulders
- ☐ Frequent neck pain
- ☐ Lower back problems
- ☐ Digestive Problems
- ☐ Heart Attack/ Stroke
- ☐ Congenital Heart Defect
- ☐ Heart Surgery/Pacemaker
- ☐ Heart Murmur
- ☐ Asthma
- ☐ Arthritis
- ☐ Alcohol/Drug Abuse
- ☐ Venereal Disease
- ☐ HIV/Aids
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Shingles
- ☐ Kidney Problems
- ☐ Hepatitis
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Psychiatric Problems
- ☐ Depression

For Women:

Are you pregnant?	☐ Yes ☐ No	Do you experience painful periods?	☐ Yes ☐ No
Are you nursing?	☐ Yes ☐ No	Do you have irregular cycles?	☐ Yes ☐ No
Are you taking birth Control?	☐ Yes ☐ No	Do you have breast implants?	☐ Yes ☐ No

Authorization For Care

I hereby authorize the Chiropractor(s) to work with me through the use of adjustments to my spine, as he or she deems appropriate.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Chiropractor(s) will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable. I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered.

_____/_____ _____ /_____

Signature Date Parent, Guardian or Spouse Authorizing Care Date

Thank you for choosing Hart Family Chiropractic. We look forward to serving you with quality chiropractic care.