HEALTHY LIVING
Family Chiropractic

Patient# __________

# WELCOME…

Today's Date ____/____/______

***Please fill out this form as completely as possible. Please print.***

## PERSONAL INFORMATION

Name________________________________________ What you prefer to be called______________________________

Age_____ Date of Birth____/____/______ Sex___ SS#______________________ E-Mail__________________________

Home Address___________________________________ City_______________________ State______ Zip___________

Contact Numbers: Cell (_____) _______________ Home (_____) _______________ Work (_____) _______________

*Preferred method of being reminded of appointments:* ◻ *Phone Call* ◻ *Text Message (no charge to you)* ◻ *E-mail*

*If text message reminders, we also need your cell phone carrier in order to send text:* ______________________

Occupation____________________ Employer____________________ City________________ State______ Zip________

Marital Status: ◻ Single ◻ Married ◻ Separated ◻ Divorced ◻ Widowed ◻ Living With

Spouse/Partner___________________________________

Emergency Contact___________________________ Relationship__________________ Phone (_____) ______________

**Whom may we thank for referring you to our office?** ___________________________________________________

## REASONS FOR SEEKING CHIROPRACTIC CARE

*At Healthy Living Family Chiropractic, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future.*

Please briefly describe the main concern that you would like Healthy Living Family Chiropractic to address for you.

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

Are these concerns affecting your quality of life? (Please check those applicable to you)

◻ Work ◻ School ◻ Exercise/Sports ◻ Driving ◻ Walking ◻ Eating

◻ Sleep ◻ Sitting ◻ Love Life ◻ Hobby – please list______________________________

When did the issue start? _______________________ What brought it on? ______________________________________

Have you had this problem before? ◻ No ◻ Yes – please explain ____________________________________________

If you are experiencing pain, where is it located? ____________________________________________________

Describe the symptoms ◻ Sharp ◻ Dull ◻ Achy ◻ Numb ◻ Tingling ◻ Stabbing ◻ Throbbing

Does the pain travel/radiate anywhere? ◻ No ◻ Yes – please describe________________________________

Since the problem started, it is? ◻ About the same ◻ Getting better ◻ Getting worse

What makes it worse? ◻ Standing ◻ Walking ◻ Sitting ◻ Lying

◻ Bending ◻ Lifting ◻ Twisting ◻ Coughing ◻ Other ________________________

What have you done for this condition that has helped you feel better? __________________________________________

What have you done for this condition that was of no help? ____________________________________________________

Are you currently wearing ◻ Heel lift R/L ◻ Arch Supports ◻ Neither

## HEALTH CARE PRACTITIONER HISTORY

Other doctors seen for ***this condition***: ◻ Chiropractor ◻ Medical Doctor ◻ Other – please list____________________

Name________________________________ City_____________________________ Date__________________

X-rays taken ◻ No ◻ Yes ___________________ Special tests done ◻ No ◻ Yes ________________________

Diagnosis____________________________ What was done____________________________________________

Have you ever had ***chiropractic care***? ◻ No ◻ Yes Name of D.C.__________________________________________

How long under care? ◻ _____days ◻ _____weeks ◻ _____months ◻ _____years

Date of last visit_________________ Why did you stop care? ___________________________________________

Are you satisfied with the care you received there? ◻ No ◻ Yes

## FAMILY HISTORY

Mother: ◻ In good health ◻ Heart ◻ Diabetes ◻ High Blood Pressure ◻ Respiratory Problems

◻ Kidney ◻ Stroke ◻ Cancer ____________________ ◻ Other ____________________

Father: ◻ In good health ◻ Heart ◻ Diabetes ◻ High Blood Pressure ◻ Respiratory Problems

◻ Kidney ◻ Stroke ◻ Cancer ____________________ ◻ Other ____________________

Siblings: ◻ In good health ◻ Heart ◻ Diabetes ◻ High Blood Pressure ◻ Respiratory Problems

◻ Kidney ◻ Stroke ◻ Cancer ____________________ ◻ Other ____________________

## YOUR HEALTH PROFILE

*The information below will help us to see the types of PHYSICAL, CHEMICAL & EMOTIONAL stresses you have been subjected to and* ***how they may relate to your present spinal, nerve and health status.***

GENERAL HISTORY

Please mark all symptoms you have ever had, even if they do not seem related to your current problem.

| | | | |
|---|---|---|---|
| ◻ Dizziness | ◻ Shortness of breath | ◻ Depression | ◻ Ulcers |
| ◻ Loss of balance | ◻ Pain in ribs/chest | ◻ Nervousness | ◻ Menstrual irregularity |
| ◻ Fainting | ◻ Neck pain/stiffness | ◻ Tension | ◻ Menstrual pain |
| ◻ Headache | ◻ Back pain (mid/low) | ◻ Fever | ◻ Urinary problems |
| ◻ Seizures | ◻ Pins/Needles in arms/legs | ◻ Allergies | ◻ Sinus problems |
| ◻ Stroke | ◻ Numbness in fingers/toes | ◻ Hot flashes | ◻ Skin issues |
| ◻ Visual disturbances | ◻ Cold hands/feet | ◻ Cold sweats | ◻ Recurrent Colds/Flu |
| ◻ Loss of smell | ◻ Fatigue/Low energy | ◻ Heart burn | ◻ Fibromyalgia |
| ◻ Buzz/Ring in ears | ◻ Sleeping problems | ◻ Heart attack | ◻ Diabetes |
| ◻ Loss of taste | ◻ Irritability | ◻ Stomach upset | ◻ Cancer __________________ |
| ◻ Nausea | ◻ Mood swings | ◻ Diarrhea/Constipation | ◻ Other ___________________ |

Please list any other ***serious medical condition(s)*** you currently have or ever had:

______________________________________________________________________________

______________________________________________________________________________

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

*The minor and often ignored repetitive physical traumas that we have endured are often too numerous to list.*
Please list the major traumas that you remember from your childhood up to the present.

Have you had any ***accidents or injuries in your life*** related to any of the following? (check all that apply)

□ Automobile □ Motorcycle □ Bicycle □ Sports □ Playground □ Abuse □ None

If yes, state type of injury and date: ______________________________________________

______________________________________________________________________________

Have you ever ***hurt/injured*** your spine, head, neck, ribs, chest, upper and lower back, pelvis or hips? □ No □ Yes

If yes, state type of injury and date: ______________________________________________

______________________________________________________________________________

Have you ever been ***hospitalized*** or had any ***surgeries***? □ No □ Yes

If yes, state reason and dates: ___________________________________________________

______________________________________________________________________________

## PREGNANCY HISTORY

PREVIOUS PREGNANCIES

Have you ever been **pregnant before**? □ No □ Yes – If yes, how many times? ______

Were there any **problems during your past pregnancies**? □ No □ Yes – If yes, please explain.

______________________________________________________________________________

______________________________________________________________________________

Were there any **problems during labor and deliveries**? □ No □ Yes – If yes, please explain.

______________________________________________________________________________

______________________________________________________________________________

What was the **presentation of the baby** during the third trimester?

□ Normal □ Breech □ Transverse □ Face/Brow □ I don't remember

Please check any of the following that are true regarding your **previous birth**.

□ Normal Vaginal □ Planned Cesarean □ Emergency Cesarean □ Water Birth

□ Suction □ Vacuum □ Forceps □ Other Intervention ______________

Did you receive an **epidural** during any or all of the deliveries? □ No □ Yes

CURRENT PREGNANCY

What **week of pregnancy** are you in? ______ Are you **carrying multiples**? □ No □ Yes

Do you plan to have an **induced labor**? □ No □ Yes Do you plan to have a **cesarean delivery**? □ No □ Yes

What **type of provider** are you using for prenatal care? □ OB/GYN □ Family Practitioner □ Midwife

Name of Practitioner ____________________________________ Clinic Location ______________________

Please check which of the following you are **experiencing with this pregnancy** and explain.

□ Abnormal Bleeding ________________________________________________

□ Motor Vehicle Accident ________________________________________________

□ High Blood Pressure ________________________________________________

□ Diabetes ________________________________________________

□ Anemia ________________________________________________

□ Falls ________________________________________________

□ Swollen Ankles ________________________________________________

□ Morning Sickness ________________________________________________

□ Indigestion ________________________________________________

□ Back Pain ________________________________________________

□ Leg Pain ________________________________________________

□ Neck Pain ________________________________________________

□ Headaches ________________________________________________

□ Hospitalizations ________________________________________________

□ Other ________________________________________________

SOCIAL HISTORY WHILE PREGNANT

Do you **exercise** regularly? □ No □ Yes How many times a week? _____ For how long? _____min

What activities do you do? ________________________________________________

Do you eat a **balanced diet**? □ No □ Yes Are you on a **special diet**? □ No □ Yes

Are you taking **prenatal vitamins**? □ No □ Yes What brand? ______________________________

Please list any **medications** you are taking while pregnant: ________________________________________________

________________________________________________

Please list any **herbs/vitamins/minerals/homeopathics** you are taking while pregnant:

________________________________________________

Do you **smoke**? □ No □ Yes

Do you drink **caffeinated beverages**? □ No □ Yes – if yes, how many per day? ______

Are you taking any **childbirth education classes**? □ No □ Yes – if yes, please describe.

________________________________________________

Please describe the **goal of your labor and delivery** for this pregnancy (examples: hospital, home, natural, medicated, vaginal, use of water, other thoughts, etc.) ________________________________________________

________________________________________________

EMOTIONAL STRESS

*It is difficult to separate the emotional stress in our life from the physical response that often occurs.*

Please indicate if you have experienced any of the emotional stresses below. (check all that apply)

□ Loss of loved one □ Work or School □ Divorce/Separation □ Financial □ Lifestyle change □ Self-esteem

QUALITY OF LIFE

How do you grade your ***physical health***? □ Good □ Fair □ Poor

How do you grade your ***emotional/mental health***? □ Good □ Fair □ Poor

How do you rate your overall ***"quality of life"***? □ Good □ Fair □ Poor

## ADDITIONAL QUESTIONS

If there is a need for ***dietary changes or nutrients***, would you like to be informed? □ Yes □ No

If there is a need for ***specific exercises***, would you like to be informed? □ Yes □ No

If there is a need for support in the ***emotional/stress area of health***, would you like to be informed? □ Yes □ No

Is there any ***specific health topic*** you would like more information on? ______________________________________

## EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (check all that apply)

□ Relief of a symptom or problem

□ Relief and Prevention of a symptom or problem

□ Healthier spine and nerve system

□ Best possible health on all levels

## COMMUNICATION INFORMATION

So we may meet your expectations, please answer this last question.
Out of the four following options, how would your ***best friend*** or ***significant other*** best describe you?

□ Straight to the point □ Social & Outgoing □ Steady & Dependable □ Cautious & Perfectly Accurate

## PLEASE READ AND SIGN BELOW

The information I have provided on these forms is correct and accurate to the best of my knowledge. I give the doctors of Healthy Living Family Chiropractic permission to render care to me today. The initial visit includes a professional and complete health history/consultation and chiropractic examination/evaluation.

Signature ______________________________________________________________ Date ____/____/______

***Thank you for choosing our practice!***

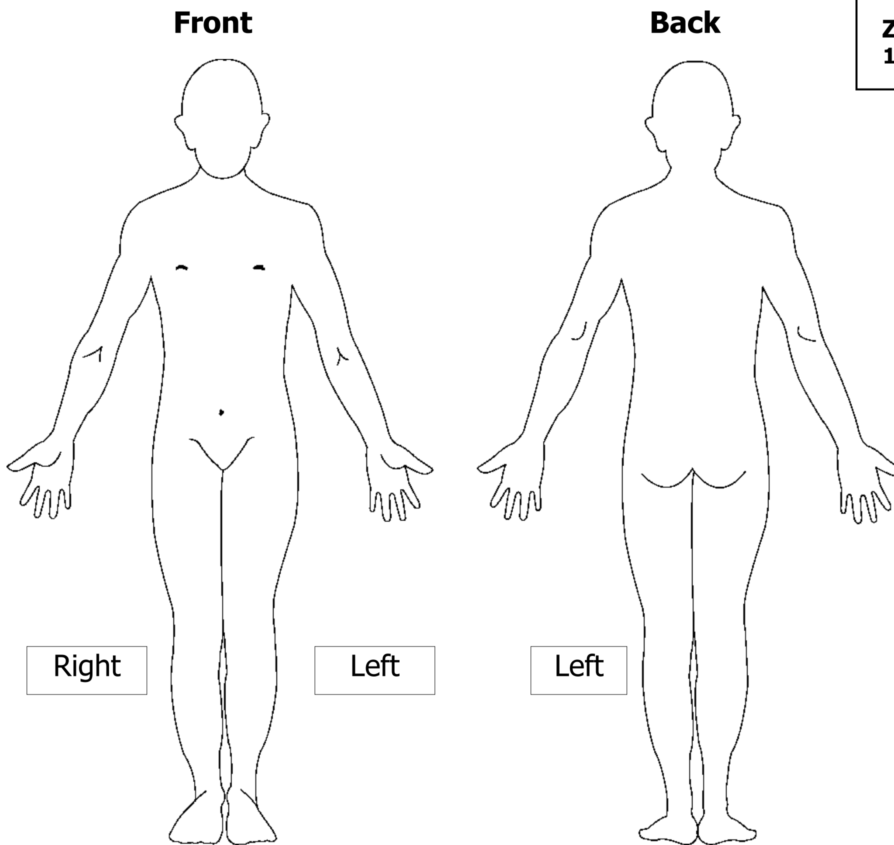
***We are here to serve you and we encourage you to ask questions.***

***Your participation is vital and will help determine your results.***

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation.
Include all affected areas.

| Numbness | Pins & Needles | Burning | Aching | Stabbing |
|---|---|---|---|---|
| - - - - - | 00000 | xxxxx | ***** | / / / / / |
| - - - - - | 00000 | xxxxx | ***** | / / / / / |
| - - - - - | 00000 | xxxxx | ***** | / / / / / |

**PAIN CHART**




**PAIN SCALE**

**Please mark on the pain scale (below) from Zero to 10 the pain you feel with this condition.**
**10 = the worst pain you have felt with this condition.**

**Neck-Shoulder-Arm Pain**
On a scale of zero to 10, I rate my discomfort as follows:
**(_______________________)**
**0** **10**
**no pain** **severe pain**

**Mid Back Pain**
On a scale of zero to 10, I rate my discomfort as follows:
**(_______________________)**
**0** **10**
**no pain** **severe pain**

**Low Back and Leg Pain**
On a scale of zero to 10, I rate my discomfort as follows:
**(_______________________)**
**0** **10**
**no pain** **severe pain**

Signature ______________________________________ Date __________________