PERSONAL HISTORY

Date ______________________

Dear Patient:
Please complete this questionnaire. Your answers will assist us in determining if Chiropractic can help you. Please answer ALL questions. Even if they seem unrelated to your case. There are conditions Chiropractic can help that you may be unaware of. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case.

Name ____ Preferred Name ______________________________

Mailing Address ____ City ____________________ Postal Code _______________

Email Address _______________________________________ Email Appointment Reminders (Y / N) Email Marketing (Y / N)

Phone: Home ___________________________ Work ____________________________ Cell ___________________________

Health Care No. ___________________________________ Age __________ Weight ______________ Height ______________

Birth date - Day ________ Month ____________ Year ___________ Birthplace ______________________________________

Gender (M / F) Marital Status (S / M / W / D / CL) Spouse's Name ________________________ # of Children ____________

Occupation _________________________________ Employer ____

Referred to this office by _______________________________ Family M.D. ____

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Parent or Guardian ☐ Other ______________________________

Emergency Contact Name _____________________________ Emergency Contact Phone Number ______________________

CURRENT HEALTH CONDITION

Present complaint ____

Have you had any previous treatment for this condition? ____

When did this condition begin?____ Is this a WCB case? ___________

What do you believe caused this condition? ____

Are there others in your family with this same condition? ____

Have you had any time loss from work for this condition? (If recent list dates) ____

Are you presently taking medication? (please list) ____

PAST HEALTH HISTORY

Major surgery/operations:
☐ Appendix ☐ Tonsils ☐ Gall Bladder ☐ Hernia
☐ Heart ☐ Back ☐ Neck ☐ Leg
☐ Other ____

Major accidents or falls ____

Previous Chiropractic Care ____

Previous Massage Therapy ____

Have you been treated for any health condition in the last year? ☐ Yes ☐ No

If yes, please explain ____

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

GENERAL

- ☐ Headache
- ☐ Numbness or tingling in arms or legs
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Whiplash
- ☐ Fainting
- ☐ Earache
- ☐ Sore throat
- ☐ Nose bleeds
- ☐ Sinus problems
- ☐ Asthma
- ☐ Enlarged glands
- ☐ Loss of weight
- ☐ Hypoglycemia
- ☐ Nervousness
- ☐ Depression/confusion
- ☐ Vision problems
- ☐ Dental problems
- ☐ Hearing problems
- ☐ Sleep problems

ORGANS

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Bladder trouble
- ☐ Kidney stones
- ☐ Bed wetting
- ☐ Prostate problems
- ☐ Sexual dysfunction
- ☐ Anemia
- ☐ Thyroid
- ☐ Excessive appetite
- ☐ Gas/bloating
- ☐ Nausea or vomiting
- ☐ Constipation/diarrhea
- ☐ Colitis
- ☐ Black/bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gallbladder trouble

MUSCLE & JOINT

- ☐ Sore joints
- ☐ Sore muscles
- ☐ Low back problems
- ☐ Neck problems
- ☐ Painful tailbone
- ☐ Pain between shoulders
- ☐ Spinal curvature
- ☐ Arthritis
- ☐ Walking problems
- ☐ Broken bones
- ☐ Jaw problems (TMJ)
- ☐ Ankle swelling
- ☐ Limb pain

RESPIRATORY & HEART

- ☐ Lung problems
- ☐ Chronic cough
- ☐ Spitting up blood
- ☐ Frequent colds/flu
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Heart problems

SKIN

- ☐ Eczema
- ☐ Skin eruptions
- ☐ Varicose veins

FEMALES ONLY

- ☐ Painful periods
- ☐ Irregular cycle
- ☐ Cramps, backache
- ☐ Vaginal discharge/infection
- ☐ Lumps/pain in breast
- ☐ Previous miscarriage
- ☐ Unable to get pregnant
- ☐ Hot flashes

Are you pregnant?

- ☐ Yes
- ☐ No
- ☐ Not sure

When was your last period?_______________

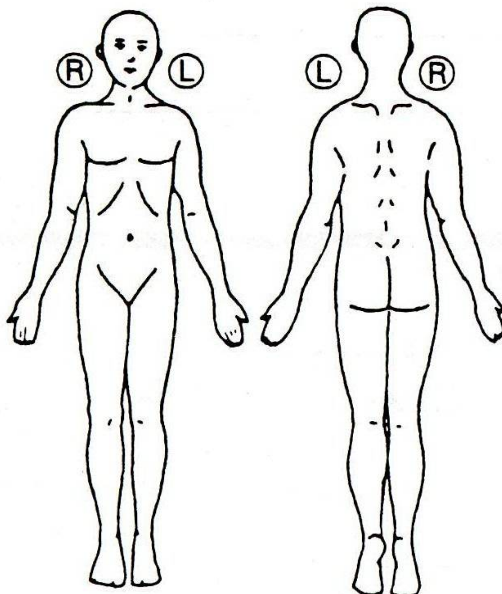
Check any of the following diseases you have had:

☐ Alcoholism	☐ Heart disease	☐ Epilepsy	☐ Stroke	☐ Arthritis	☐ Hypoglycemia
☐ Tuberculosis	☐ Rheumatic fever	☐ Diabetes	☐ Cancer	☐ HIV / AIDS	☐ Allergies

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

☐ Heart disease ☐ High blood pressure ☐ Cancer ☐ Stroke ☐ Arthritis

Please indicate any areas of discomfort



Lifestyle

	none	light	moderate	heavy
Exercise	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tea	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Junk Food	☐	☐	☐	☐
Stress	☐	☐	☐	☐