

PERSONAL HISTORY

Have you ever had your spine or nervous system examined professionally? Yes / No

If yes, when and by whom? _____

Have you ever had X-rays, CAT Scans, or MRIs of your spine or Extremities? Yes / No _____

Have you received chiropractic adjustments by a Doctor of Chiropractic? Yes / No

If yes, for how long? _____ How often did you go? _____

When was your last visit? _____ Why did you stop? _____

Were you pleased with his/her service? Yes / No _____

What type of adjustments, technique(s), or method(s) did he/she use (if known)? _____

Does your immediate family receive chiropractic adjustments? _____

Have you had, or do you receive, any of the following for growth and development?

Bodywork/Massage: Yes / No Osteopathy/Cranial work: Yes / No Prayer/Meditation: Yes / No

Psychotherapy: Yes / No Movement or Exercise: Yes / No Yoga: Yes / No

Rebirthing/Breathwork: Yes / No Other: Yes / No _____

Chiropractic practice is based upon the location and adjustment of vertebral subluxations. (Spinal) subluxations are caused by any stress your body can not properly perceive, adapt to or recover from. These stresses may be *physical*, *chemical*, or *emotional* in nature. The following questions will provide more clues about your unresolved stress levels.

PHYSICAL STRESS

BIRTHHISTORY: (Please try to obtain this information. It is important to your care.)

Did your mother have a difficult pregnancy with you? Yes / No

Explain _____

Did your mother have any falls, accidents, physical injuries, or illnesses during pregnancy? Yes / No

Explain _____

Were you born at: Home / Hospital / Birthing Center. Were you Incubated or Isolated after birth? Yes / No

Was your delivery traumatic? (Circle all that apply)

Drug Induced Labor Forceps Or Suction C-Section Cord Around Neck Breech Prolonged

Explain _____

Were you: BottleFed Formula Bottle Fed Mother's Milk Nursed

PHYSICAL STRESS

GENERAL PHYSICAL TRAUMA

Take a few moments to reflect on your personal history before answering these questions, recalling any physical injuries you experienced since childhood.

Have you ever had any injuries that “took you out of commission” for a full day or more? Yes / No

Describe _____

Were you ever knocked unconscious? Yes / No

Have you ever used crutches, a walker, or a cane? Yes / No

Have you ever broken any bones? Yes / No _____

Have you ever had any impacts, falls, or jolts that you felt specifically may have injured your head/spine? Yes / No

Have you had extensive dental or orthodontal work performed? Yes / No

Which of these describe your day? (circle all that apply) Sit Stand Walk Drive
 Phone work Mechanical work Repetitive work Heavy lifting

How old is your mattress? _____ Is it comfortable? Yes / No

How old is your pillow? _____ Is it comfortable? Yes / No

How often do you exercise? Daily Weekly Monthly Describe: _____

SPORTS OR LEISURE

Were you previously active in any particular sports or hobbies? Yes / No Which ones? _____

Are you currently active in any particular sports or hobbies? Yes / No Which ones? _____

Have you been injured in any of these activities? Yes / No Comments _____

Are there activities for which you spend any length of time in particular position (TV, reading, musician, etc.)? Yes / No

Comments: _____

VEHICULAR ACCIDENTS

Have you been involved in a vehicular collision/near collision, either as the driver or as a passenger, even if you do not think you were injured? Yes / No Please list the approximate dates and severity (Mild, Moderate, Extreme).

Automobile: _____

Bus, Bicycle, Motorcycle, etc. _____

How do you rate your physical health since? Excellent / Good / Fair / Poor

Is it: Getting Better / About the Same / Getting Worse ?

FOOD & DIETARY HABITS / CHOICES

Please indicate how often you consume the following: (ex.: 2x/day, 3x/week)

Alcohol _____

Artificial Sweeteners _____

Beef _____

Butter _____

Carbonated Drinks _____

Coffee _____
(Reg Or Decaf)

Dairy _____
(Milk Products)

Diet Food _____

Eggs _____

Fast Food _____

Fish _____

Fried Food _____

Fruit, Canned _____

Fruit, Fresh _____

Grains, Refined _____
(White Bread, Pasta, Etc.)

Grains, Whole _____
(Pasta, Bread, Etc.)

Margarine _____

Organic Foods _____

Pork _____

Poultry _____

Raw Food _____

Refined Sugar _____
(Candy/Junk Food) (Added)

Salt _____

Seafood _____
(Shrimp, Scallops, Etc.)

Tobacco _____

Vegetables, Canned/Frozen _____

Vegetables, Fresh _____

Water _____

Fasting _____

Please list any vitamins, minerals, or herbs you take _____

Please describe any other types of food you eat: _____

How would you classify your diet? _____

How would you rate your food habits? Excellent / Good / Fair / Poor

Are your food habits: Getting Better / About the Same / Getting Worse ?

Bowel movements? _____ per Day / Week

Urination? _____ per day

CHEMICAL STRESS

BIRTH HISTORY

Was your mother regularly taking any drug prior to or during her pregnancy with you?

Alcohol / Tobacco / Other _____

Was her labor chemically induced or altered? Yes / No Explain _____

During your delivery, was your mother: Conscious / Semiconscious / Unconscious

Was your mother exposed to any other chemicals during her pregnancy? _____

GENERAL CHEMICAL TRAUMA:

Did you or do you work with any chemicals, fumes, dust, or smoke for long periods? Yes / No

Please list them _____

Please indicate any drugs you have taken in the Past (P), or are Currently taking (C):

Allergy/Cold/Flu	P / C	Birth Control Pills	P / C	Ulcer Medication	P / C
Antacids	P / C	Blood Pressure Meds	P / C	Vaccinations	P / C
Anti-Anxiety/Depression	P / C	Heart Medication	P / C	Other (Please List)	
Antibiotic/Antifungal	P / C	Hormones	P / C	_____	P / C
Antidiabetic/Insulin	P / C	Laxatives	P / C	_____	P / C
Anti-inflammatory/ Cortisone	P / C	Lithium	P / C	_____	P / C
Antiparasite (Worms)	P / C	Recreational	P / C	_____	P / C
Aspirin/Tylenol/ Ibuprofen	P / C	Relaxants/Sleeping Pills	P / C	_____	P / C
		Stimulants	P / C	_____	P / C
		Thyroid	P / C	_____	P / C

Comments: _____

EMOTIONAL STRESS

Please circle the level of severity, and whether Past (P) or Current (C), for each of the following spinal stress situations

	<u>Mild</u>	<u>Moderate</u>	<u>Extreme</u>		<u>Mild</u>	<u>Moderate</u>	<u>Extreme</u>
Childhood Stress	P / C	P / C	P / C	Work-Related Stress	P / C	P / C	P / C
School Stress	P / C	P / C	P / C	Stress of Commuting	P / C	P / C	P / C
Play or Recreation	P / C	P / C	P / C	Loss of Loved One	P / C	P / C	P / C
Family Stress	P / C	P / C	P / C	Change in Lifestyle	P / C	P / C	P / C
Stress of Being Sick	P / C	P / C	P / C	Change in Vocation	P / C	P / C	P / C
Personal Relationships	P / C	P / C	P / C	Abuse (Physical, Emotional, Sexual)	P / C	P / C	P / C

How do you rate your Emotional/Mental Health? Excellent / Good / Fair / Poor

Do you feel it is getting: Better / Worse

Comments: _____

MEDICAL TREATMENT

Have you ever had any of the following procedures? Circle all that apply.

- | | | | |
|-----------------------------|-------------------|-----------------------------------|------------------|
| Bone in cast/Immobilized | Chemotherapy | Corrective shoes or bars on shoes | |
| Extensive diagnostic x-rays | Heel lift | Neck collar | Physical therapy |
| Spinal brace | Spinal injections | Spinal tap | Traction |
| Transfusion | X-ray treatments | | |

Have you ever been hospitalized? Yes / No When and what was done? _____

Have you ever had surgery? Yes / No When and what was done? _____

PREGNANCIES

Number of Pregnancies _____ Number of Births _____

For each pregnancy, please complete. If you need more room, please use another sheet :

1. Your age _____ Type of delivery: Normal C-Section Chemically Induced
 Any falls, accidents, injuries, illnesses, or other complications? _____

2. Your age _____ Type of delivery: Normal C-Section Chemically Induced
 Falls, accidents, injuries or illnesses, or other complications? _____

3. Your age _____ Type of delivery: Normal C-Section Chemically Induced
 Falls, accidents, injuries or illnesses, or other complications? _____

OTHER

Is there anything which may help us better understand you, which has not been covered in this form?
