



# Health History Information:

Welcome!

**Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Mailing Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail Address \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_ # of children \_\_\_\_\_

Home Ph. \_\_\_\_\_ WorkPh. \_\_\_\_\_ Cell Ph. \_\_\_\_\_

Have you been under Chiropractic Care before? Yes or No Date of last visit: \_\_\_\_\_

Whom can be thanked for referring you? \_\_\_\_\_

Reason for seeking chiropractic care: \_\_\_\_\_

When did it first start? \_\_\_\_\_ What do you think caused it? \_\_\_\_\_

On a scale of 1 to 10, RATE your PAIN? (1 being the least, 10 the worst) - 1 2 3 4 5 6 7 8 9 10 -

Is it affecting your daily living? Yes or No How? \_\_\_\_\_

Have you consulted any other healthcare providers about this? Yes or No

Whom: \_\_\_\_\_ When: \_\_\_\_\_ Result \_\_\_\_\_

Is this related to a work or auto accident? Yes or No

List medications or drugs being taken: \_\_\_\_\_

**List with approximate DATES the following....**

Surgeries undergone: \_\_\_\_\_

Hospitalizations : \_\_\_\_\_

Bone fractures: \_\_\_\_\_

Vehicle accidents: \_\_\_\_\_

Serious falls: \_\_\_\_\_

Date of last medical examination: \_\_\_\_\_ Dr.'s Name: \_\_\_\_\_

Result of your last medical exam: \_\_\_\_\_

List any hobbies: \_\_\_\_\_

Do you exercise? Yes or No (type) \_\_\_\_\_

Please add any additional information that you feel the Doctor should know about.

\_\_\_\_\_

\_\_\_\_\_

Over.....



