57th Street Chiropractic and Wellness Center

Personal and Family Health History (PLEASE BE COMPLETE AS POSSIBLE)

Name _____
Address _____
City _____ State ____ Zip _____
Phone: (H) _____
(W) _____
Cell phone number _____
E-mail _____
Date of Birth _____ (Age _____)

Referred By _____
Social Security # _____
Occupation _____
Employer _____
Marital Status S☐ M☐ D☐ W☐ DP☐
Spouse/Partner Name _____
Spouse/Partner Occupation _____

Number of Children and Ages **Previous Chiropractic Care?**

Name _____ Age _____ Yes___ No___ Reason _____
Name _____ Age _____ Yes___ No___ Reason _____
Name _____ Age _____ Yes___ No___ Reason _____
Name _____ Age _____ Yes___ No___ Reason _____

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Check all that Apply

	Patient	Spouse	Child#1	Child#2	Child #3	Chiropractor's Comments
1. Was Your Birth Traumatic?						
Long Delivery?	☐	☐	☐	☐	☐	_____
Difficult Delivery?	☐	☐	☐	☐	☐	_____
Forceps?	☐	☐	☐	☐	☐	_____
Caesarian?	☐	☐	☐	☐	☐	_____
Breach/cephalic?	☐	☐	☐	☐	☐	_____
Home birth?	☐	☐	☐	☐	☐	_____
Mother given drugs during delivery	☐	☐	☐	☐	☐	_____
Induced Labor?	☐	☐	☐	☐	☐	_____
2. Growth and Development						
Did you ever once...						
Learn to care for your spine?	☐	☐	☐	☐	☐	_____
Fall out of bed?	☐	☐	☐	☐	☐	_____
Bang your head?	☐	☐	☐	☐	☐	_____
Breastfeed?	☐	☐	☐	☐	☐	_____
Childhood sickness	☐	☐	☐	☐	☐	_____
Have any Accidents?	☐	☐	☐	☐	☐	_____
Have Surgery?	☐	☐	☐	☐	☐	_____
Take Drugs?	☐	☐	☐	☐	☐	_____
Fall while learning to walk?	☐	☐	☐	☐	☐	_____
Bullied by your siblings?	☐	☐	☐	☐	☐	_____
Child abuse	☐	☐	☐	☐	☐	_____
Spanking?	☐	☐	☐	☐	☐	_____
Pulled ear/chin	☐	☐	☐	☐	☐	_____
Other	☐	☐	☐	☐	☐	_____
Chair pulled out when sitting?	☐	☐	☐	☐	☐	_____
Fall down the stairs?	☐	☐	☐	☐	☐	_____
Pulled by your arm?	☐	☐	☐	☐	☐	_____
Experience other traumas?	☐	☐	☐	☐	☐	_____
3. Current Health Habits						
Did/do you...						
Smoke?	☐	☐	☐	☐	☐	_____
Drink?	☐	☐	☐	☐	☐	_____
Diet (do you eat healthy foods?)	☐	☐	☐	☐	☐	_____
Have you been in accidents?	☐	☐	☐	☐	☐	_____
Have you had surgery						
And organs replaced/removed?	☐	☐	☐	☐	☐	_____

PLEASE CONTINUE OTHER SIDE

Drugs? (Prescriptive or Non-Prescriptive	☐	☐	☐	☐	☐	_____
Have Teeth Problems?	☐	☐	☐	☐	☐	_____
Have Eye Problems?	☐	☐	☐	☐	☐	_____
Have Hearing Problems?	☐	☐	☐	☐	☐	_____
Exercise regularly?	☐	☐	☐	☐	☐	_____
Have sleeping problems? (Nightmares)?	☐	☐	☐	☐	☐	_____
Have occupational stress?	☐	☐	☐	☐	☐	_____
Have physical stress?	☐	☐	☐	☐	☐	_____
Have mental stress?	☐	☐	☐	☐	☐	_____
Have hobbies/sports injuries?	☐	☐	☐	☐	☐	_____
Sleeping posture – side–stomach–back	_____					

Current Health Condition

Present Complaint (be brief) Reason for Your Visit Today
Major _____
Pain or Problem started on _____
Pains are: ☐ Sharp ☐ Dull ☐ Constant ☐ Intermittent
What activities aggravate your condition/pain? _____
What activities lessen your condition/pain? _____
Is condition worse during certain times of the day? _____
Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
Is this condition getting progressively worse? _____
Other Doctors seen for this condition _____
Any home remedies? _____

Other symptoms:

☐ Headaches	☐ Pins & Needles in Legs	☐ Fainting
☐ Neck Pain	☐ Pins & Needles in Arms	☐ Cold Sweats
☐ Sleeping Problems	☐ Numbness in Fingers	☐ Loss of Smell
☐ Back Pain	☐ Numbness in Toes	☐ Loss of Taste
☐ Nervousness	☐ Shortness of Breath	☐ Diarrhea
☐ Tension	☐ Fatigue	☐ Feet Cold
☐ Irritability	☐ Depression	☐ Hands Cold
☐ Chest Pains	☐ Light Bothers Eyes	☐ Stomach Upset
☐ Dizziness	☐ Loss of Memory	☐ Constipation
☐ Face Flushed	☐ Ears Ring	☐ Loss of Balance
☐ Neck Stiff	☐ Fever	☐ Buzzing in Ear

Have you been under drug and medical care? _____
What medications are you taking? _____
How Long? _____ Have you had surgery? _____ What? _____ When? _____
What side effects have you experienced from the drugs and surgery? _____
_____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	☐	☐	☐	☐	☐
Mother's Side	☐	☐	☐	☐	☐

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.
As a result of my chiropractic care, I would like to

Please check all that apply

☐ Feel better quickly
☐ Have a healthier spine
☐ Have a healthier body by keeping my nerve system healthy
☐ Live a healthier lifestyle

_____ _____
Signature Date