

Confidential Health Concern History

Personal Information:

Last Name: _____ First Name: _____
Social Security: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Postal Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Best number to reach you? _____ **Best time to reach you?** _____
Occupation: _____ Employer: _____
Care Card Number: _____ Family Physician: _____
Who may we thank for your referral to our office? _____
Names and ages of children: _____
E-mail address: _____ May we send you office letters? Yes No

Health Information:

What are your objectives in consulting our office? _____
What are your health goals once these objectives have been met? _____
Who was the last doctor who created a health development plan for you? _____
Did you follow all the Doctor's recommendations? Yes No
How long were you able to stay on the health development plan? _____
What were the results? _____
What other wellness professionals are currently a part of your health care team?
 Massage Therapist Acupuncturist Naturopath Homeopath Other _____
How many Medical Doctor's office visits did you and your family have last year?
 None Less than 5 More than 5 More than 10
Have you had previous Chiropractic care? Yes No This year? Yes No
List previous surgeries and dates: _____
Medications: Pain Meds Birth Control Heart Meds
 Cholesterol Meds Other _____

Lifestyle Information:

Do you exercise? Yes No If yes, how much and how often? _____
Do you smoke? Yes No If yes, how much? _____
Do you consume alcohol? Yes No If yes, how much and how often? _____
Do you drink water? Yes No If yes, how much per day? _____

Please check all of the following health concerns that you have experienced, even if you do not think that your answers relate to your present health concern.

| | | | |
|----------------------|--|------------------------|--|
| Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Condition | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anxiety | <input type="checkbox"/> Yes <input type="checkbox"/> No | Immune System Disorder | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Infertility | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No | Menstrual Cramps | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bladder Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mood swings | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Neck Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory/Vascular | <input type="checkbox"/> Yes <input type="checkbox"/> No | Numbness/Tingling | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diarrhea | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Digestive Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin condition | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Urinary Difficulty | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vertigo | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heartburn/Reflux | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Stress History:

Please indicate whether you have ever experienced stress in any of the following areas. Your answers will enable us to determine which factors have contributed to your present health concerns.

1) Childhood

| | | | |
|------------------------------------|--|--|--|
| Repeated /Prolonged Antibiotic Use | <input type="checkbox"/> Yes <input type="checkbox"/> No | Inhaler Use | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Car Accident | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prescription Medications | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Childhood Illness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fall/Jump from a Height <3 feet | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaccination | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fall/Jump from a Height >3 feet | <input type="checkbox"/> Yes <input type="checkbox"/> No | Youth Sports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Head Trauma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Traumas (physical or emotional): | |

2) Adulthood

| | | | |
|-----------------------------------|--|--|--|
| Alcohol Consumption | <input type="checkbox"/> Yes <input type="checkbox"/> No | Inhaler Use | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Repeated/Prolonged Antibiotic Use | <input type="checkbox"/> Yes <input type="checkbox"/> No | Prescription Medications | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Car Accident | <input type="checkbox"/> Yes <input type="checkbox"/> No | Smoker | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Coffee Drinker | <input type="checkbox"/> Yes <input type="checkbox"/> No | Surgery | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Drug Use/Abuse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Contact Sports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fall/Jump from Height | <input type="checkbox"/> Yes <input type="checkbox"/> No | Extreme Sports | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heads Trauma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Workplace Stress | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Home Environment Stress | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Traumas (physical or emotional): | |

Which best describes your reason for consulting our office?

- I have a specific concern and require help only with this concern
- I want to insure that my health concerns do not become an ongoing problem that will impact my future health.
- I want to be healthier five years from now than I am today.