

# NATURALLY CHIROPRACTIC HEALTH HISTORY

Please fill out this form as completely and accurate as possible

Today's Date \_\_\_\_\_  
Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Parent's name (if you are under 18) \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Email \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Business Address \_\_\_\_\_  
Emergency Contact and Phone Number \_\_\_\_\_  
Marital Status: S M D W Spouse/Partner Name \_\_\_\_\_  
Names and Ages of Children \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## REASONS FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Naturally Chiropractic can address for you? \_\_\_\_\_

Are these concerns affecting your quality of life? Please circle those applicable to you

Work	Y N	Driving	Y N	Sleep	Y N
School	Y N	Walking	Y N	Sitting	Y N
Exercise/sports	Y N	Eating	Y N	Love life	Y N

## HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? Y N Name of Dr \_\_\_\_\_

How long under care? \_\_\_\_\_ days \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years

Date of last visit \_\_\_\_\_ Why did you stop? \_\_\_\_\_

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

Medical Physician	Naturopath	Acupuncturist	Homeopath
Massage Therapist	Psychotherapist	Energy healer	Dentist

Reason why \_\_\_\_\_

## FOR WOMAN

Are you pregnant? Y N If pregnant, Due Date \_\_\_\_\_ Name of OB/GYN or  
Midwife \_\_\_\_\_

Where will you be birthing your baby? Hospital / Home / Birthing Center / Other \_\_\_\_\_

## PHYSICAL STRESS

Have you had any accidents or injuries in your life related to any of the following? check all that apply

Automobile Motorcycle Bicycle Sports Playground Abuse

If yes, state type or injury and date: \_\_\_\_\_

Have you ever hurt/injured your spine, head, neck, ribs, chest, upper or lower back, pelvis or hips? Y N

If yes, state type or injury and date: \_\_\_\_\_

Have you ever hurt, broken, fractured or sprained any bones or joints? Y N

If yes, list body parts injured and dates: \_\_\_\_\_

Have you ever been hospitalized? Y N

If yes, state reason and dates: \_\_\_\_\_

Name \_\_\_\_\_

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

Table with 6 columns: Childhood trauma, Work or School, Lifestyle change, Loss of loved one, Divorce/Separation, Parents divorce, Abuse, Financial, Illness. Each cell contains 'Y' and 'N' for Yes/No.

CHEMICAL STRESS

Chemical stress can occur when a substance that is toxic to the body is breathed, injected, taken by mouth or placed on the skin (e.g. food allergies, drug reactions, exposure to chemicals in the air, etc). The following will reveal exposures you may have had.

Were you vaccinated? Y N If yes, did you have a reaction? Y N

Have you been exposed to any of the following on a regular basis, (past or present)?

Toxic chemicals Second hand smoke Drug therapy Radiation Chemotherapy Other

If yes, please list \_\_\_\_\_

Do you have allergies to any foods? Y N If yes, please list \_\_\_\_\_

Do you consume any of the following presently?

Coffee/caffeine Alcohol Tobacco Over the counter drugs Prescribed drugs

Please list all medications (prescribed and over the counter) \_\_\_\_\_

\_\_\_\_\_

QUALITY OF LIFE

How do you grade your physical health? Good Fair Poor

How do you grade your emotional/mental health? Good Fair Poor

How do you rate your overall quality of life? Good Fair Poor

Do you exercise regularly? If yes, how often? \_\_\_\_\_

Do you take supplements? If yes, please list \_\_\_\_\_

Do you have a special dietary regime? If yes, what? \_\_\_\_\_

DOCTOR'S NOTES: \_\_\_\_\_

\_\_\_\_\_

Recommendations: \_\_\_\_\_

\_\_\_\_\_

Patient accepted: YES NO Referred

I have reviewed the information contained on this form with the patient

Dr's signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_