

MEDICAL HISTORY INFORMATION

First Name:	Middle:	Last:	Nickname:
Spouse's Name:			Email:
Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No Ages: _____			
Address:		City:	State: Zip:
Home Phone:		Work Phone:	Cell Phone:
Sex: Male / Female	Date of Birth:	Age:	Height: Weight: Right / Left Handed
Emergency Contact Name:		Relationship:	Phone: Do you have Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employment (circle) Employed Homemaker Student P/T F/T Child Retired Disabled		Occupation:	Employer:
Marital status (circle one) Single / Mar / Div / Sep / Widowed		Referred by:	Other family members seen here:
How would you like us to contact you for future appointments: <input type="checkbox"/> Cell Phone <input type="checkbox"/> Home phone <input type="checkbox"/> Work phone <input type="checkbox"/> Email			

MEDICAL CARE INFORMATION

Do You Have a Family Doctor/Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, would you like to have a copy of your report for this visit sent to your PCP? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Family Doctor:	Date of last Visit:	Date of last exam:
Street:	City:	State: ZIP Code:
Have you Had Surgeries in the last 5 Years: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Reason for Surgery:		

CURRENT CONDITION	THE REASON FOR THIS VISIT:		
	When did this condition begin?	Is this condition getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No	The pain/discomfort... <input type="checkbox"/> is constant <input type="checkbox"/> comes & goes
	Have you been treated by a Medical Physician for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who, when & where? _____ Phone# _____		
Have you ever been treated by a Chiropractor before? <input type="checkbox"/> Yes <input type="checkbox"/> No Was it for the current condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, who, when & where? _____ Phone: _____			

GOALS FOR MY CARE:

People see healthcare practitioners for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others to correct whatever the core malfunction maybe. Your practitioner will weigh your needs and desires when recommending your program of care. Please check the type of care desired so that we maybe guided by your wishes.

- Corrective Care**- Correcting and relieving the cause of the problem as well as the symptoms
- Relief Care**- Symptomatic relief of pain or discomfort
- Comprehensive Care**-Address the entire system and bring whatever is malfunctioning in the body to the highest state of health possible

Please check the services you are interested in receiving or acquiring more information:

- Chiropractic Acupuncture Neuro Emotional Technique Empowerment Coaching Massage Cold Laser Orthotics Immune Support
- Detox Footbaths Nutritional Assessment/Counseling Genetic Test Spectra cell: Mineral/Vitamin Def, Thyroid Adrenal panel, Cardiac Panel, Hormone
- Elisa Act: Food/Chemical Sensitivities Body Composition: Food & calorie requirement, exercise requirements

PRESENT ILLNESS /CONDITIONS:

<input type="checkbox"/> AIDS / HIV	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> Diverticulitis/Crohn's /IBS
<input type="checkbox"/> Allergies	<input type="checkbox"/> Scars	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Mental/Emotional Difficulty
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Epilepsy/Seizure
<input type="checkbox"/> Arthritis	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Hives/Rashes	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema	<input type="checkbox"/> Dislocated joints	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Cirrhosis/hepatitis	<input type="checkbox"/> Ulcer <input type="checkbox"/> Acid Reflux
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Gall Bladder	<input type="checkbox"/> Polio <input type="checkbox"/> Heartburn
<input type="checkbox"/> Headache	<input type="checkbox"/> Migraine	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Gout	<input type="checkbox"/> STD'S <input type="checkbox"/> Genetic issue

PRESCRIPTIONS:

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NUTRITIONAL SUPPLEMENTS / HERBS / HOMEOPATHIC:

SLEEP:

<input type="checkbox"/> Wake up rested	<input type="checkbox"/> Wake up rested, but energy drops after: Breakfast mid-morning Lunch mid-afternoon Dinner	<input type="checkbox"/> 2 nd wind if you stay up past bedtime	Sleep: 6hrs, 7hrs, 8hrs, 9hrs Other _____
<input type="checkbox"/> Wake up exhausted	<input type="checkbox"/> Wake up during the night	<input type="checkbox"/> Wake up in the middle of the night to Urinate	<input type="checkbox"/> Wake up in the middle of the night hungry
<input type="checkbox"/> No energy all day	<input type="checkbox"/> Hard to fall to sleep	<input type="checkbox"/> Easy to fall asleep	<input type="checkbox"/> Difficult to fall back to sleep
<input type="checkbox"/> Unable to relax enough to fall asleep <input type="checkbox"/> Thinking <input type="checkbox"/> Stress <input type="checkbox"/> Worry <input type="checkbox"/> Pain <input type="checkbox"/> Tightness	<input type="checkbox"/> Unable to stay asleep	<input type="checkbox"/> Wake up in pain	<input type="checkbox"/> Night Sweats

Other: _____

FAMILY HISTORY OF ILLNESS:

<input type="checkbox"/> AIDS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Spinal Disc Disease	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Dislocated joints
<input type="checkbox"/> Allergies	<input type="checkbox"/> Bone fracture	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Sinus trouble	<input type="checkbox"/> Cirrhosis/hepatitis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV/ARC	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Polio	<input type="checkbox"/> Mental/ Emotional Difficulty
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout	<input type="checkbox"/> Prostate trouble	<input type="checkbox"/> Thyroid trouble	<input type="checkbox"/> Diverticulitis /Crohn's /IBS
<input type="checkbox"/> Asthma	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Migraine

Other: _____

TYPE OF CANCER: Breast Lung Prostate Other: _____

SOCIAL HISTORY:

<input type="checkbox"/> Caffeine Use _____oz/day	<input type="checkbox"/> Exercise _____ hours/wk <input type="checkbox"/> Cardio <input type="checkbox"/> Weights <input type="checkbox"/> Yoga	<input type="checkbox"/> Orthotics / Shoe Insert
<input type="checkbox"/> Alcohol Consumption drinks/wk <input type="checkbox"/> Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor	Diet <input type="checkbox"/> Vegetarian Type: _____ <input type="checkbox"/> Autoimmune Protocol	
<input type="checkbox"/> Tobacco Use _____ packs/day	<input type="checkbox"/> Paleo <input type="checkbox"/> Low Carb <input type="checkbox"/> High Carb <input type="checkbox"/> Low Sodium <input type="checkbox"/> Gluten Free <input type="checkbox"/> Lactose / Casein Free	
<input type="checkbox"/> Sweeteners <input type="checkbox"/> Sugar <input type="checkbox"/> Agave <input type="checkbox"/> Stevia <input type="checkbox"/> Palm sugar <input type="checkbox"/> Honey <input type="checkbox"/> Sucanat <input type="checkbox"/> Monk Fruit <input type="checkbox"/> Splenda <input type="checkbox"/> Equal <input type="checkbox"/> Sweet'N Low <input type="checkbox"/> Xylitol <input type="checkbox"/> Erythritol <input type="checkbox"/> Swerve	Type of Mattress: _____ Age of Mattress: _____	

FEMALE REPRODUCTIVE HISTORY:

Age menses began: _____	Regular monthly period: <input type="checkbox"/> Yes <input type="checkbox"/> No	How heavy is your bleeding? <input type="checkbox"/> Light <input type="checkbox"/> Normal <input type="checkbox"/> Heavy
Date of last period: _____	<input type="checkbox"/> 21 days <input type="checkbox"/> 28 days <input type="checkbox"/> 35 days	Blood Color: <input type="checkbox"/> Light-red <input type="checkbox"/> Red <input type="checkbox"/> Dark Red <input type="checkbox"/> Purple <input type="checkbox"/> Brown <input type="checkbox"/> Black
Last Pap smear: _____	<input type="checkbox"/> Other: _____	
Painful periods? <input type="checkbox"/> Yes <input type="checkbox"/> No		
How many days of pain?: _____		

<input type="checkbox"/> Acne before or during cycle	<input type="checkbox"/> Clotting	<input type="checkbox"/> Uterine Fibroids	<input type="checkbox"/> Uterine Prolapse	<input type="checkbox"/> Pain during ovulation
<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> PMS	<input type="checkbox"/> Ovarian Fibroids	<input type="checkbox"/> Retroverted Uterus	<input type="checkbox"/> Pain during sex
<input type="checkbox"/> Spotting / Breakthrough bleeding	<input type="checkbox"/> PMDD	<input type="checkbox"/> Polyps	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Pelvic Inflammatory Disease
<input type="checkbox"/> Polycystic Ovarian Syndrome	<input type="checkbox"/> HRT	<input type="checkbox"/> Genital Herpes	<input type="checkbox"/> Fertility drugs	<input type="checkbox"/> Pelvic Adhesions
<input type="checkbox"/> Recurring Yeast Infections	<input type="checkbox"/> HPV	<input type="checkbox"/> Chlamydia	<input type="checkbox"/>	<input type="checkbox"/> Pelvic Abnormalities
<input type="checkbox"/> Chronic Vaginal discharge	<input type="checkbox"/> STDs	<input type="checkbox"/> Abnormal Pap smear	Hysterectomy?	<input type="checkbox"/> Pelvic Pain
<input type="checkbox"/> Cervical Biopsy/Cauterization/Conization	<input type="checkbox"/> D & C	<input type="checkbox"/> Yeast Infections	<input type="checkbox"/> partial (Lt / Rt Ovary)	<input type="checkbox"/> Chronic Discharge
# of Pregnancies: _____	# of Miscarriages: _____	<input type="checkbox"/> full	<input type="checkbox"/>	<input type="checkbox"/>

PREGNANCY HISTORY:

Constipation Diarrhea Yeast Infections Other _____

Allergies Rashes Hives Psoriasis Eczema Other _____

Antibiotics during delivery rH factor (rhogam shot) Antibiotics during pregnancy Positive Beta Strep Flu Shot _____

Gestational Diabetes Bed Rest Early Labor Induced Labor C-section Delivery at week --34, 35, 36, 37, 38, 39, 40

CHILDREN'S HISTORY:

Constipation Diarrhea Abnormally large bowel movements Colic Pain after eating Reflux / spitting up Bloating after eating

Rashes Hives Psoriasis Eczema Other _____

Inability to make eye contact Delayed language Difficulty expressing themselves Jumbled word pronunciation Anger outbursts Aggression

Food Sensitivities ----- Dairy Wheat/Gluten Sugar Food Coloring Other _____

Dyslexia Hard time focusing Hard time focusing to read Hard time learning math

Banging/hitting head Hitting stomach Toe Walking Flapping

Disliked tummy time Skipped crawling "Crab" crawling Early walking Started crawling at age _____ Started walking at age _____

ADD ADHD PDD ODD Autism Asperger's Other _____ Are they expressive- smile and laugh when appropriate?

Vaccinated Delayed schedule Current Vaccine Injury Other concerns: _____

Patient Signature: _____ Printed Name: _____ Date: _____

Guardian Signature: _____ Printed Name: _____ Date: _____