

FAMILY FIRST CHIROPRACTIC

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Confidential Health Record

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 system 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.

General Information

NAME

PRACTICE MEMBER #

ADDRESS, CITY, STATE, ZIP

SOCIAL SECURITY #

BIRTH DATE

AGE

SEX: M/F

EMAIL

HOME PHONE

WORK PHONE

DATE OF LAST
SPINAL CHECK-UP

CHECK ONE

SPOUSE'S NAME

Married

Single

Divorced

Widowed

EMERGENCY CONTACT

EMERGENCY CONTACT PHONE NUMBER

NAME AND AGES OF CHILDREN/SILBLINGS

WHO IS RESPONSIBLE FOR YOUR ACCOUNT?

RESPONSIBLE PARTIES SOCIAL SECURITY #

RESPONSIBLE PARTIES BIRTHDATE

IF UNDER THE AGE OF 18, MOTHER'S NAME

IF UNDER THE AGE OF 18, FATHER'S NAME

MAIN REASON FOR CONSULTING OUR OFFICE TODAY

REFERRED BY

Your Health Profile

Why this form is important – As a family wellness oriented office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a lifetime of health, happiness and vitality. On a daily basis we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious. Your answers to the following questions will give us a general view of the stresses that you have faced in your lifetime, thus allowing us to better assess your current status and more accurately determine what course of care will best help you reach your true health potential.

The Beginning years - Many of the health challenges that people face later in life have their origins in stress from developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

BIRTH HISTORY (Please check all that apply)

Mother smoke/drank/drugs during pregnancy	Epidural/meds in labor
Breech vaginal delivery	Forceps delivery
Vacuum extractor used	Labor induced
C-section delivery	Premature/overdue
Complications	Very short labor
Very long labor	Mother had falls/accidents
Hospital delivery	Birthing center delivery
Home delivery	Baby in distress
Shoulder dystocia	Erb's palsy
Broken clavicle	Severe tearing
Hemorrhaging	Failed labor
Jaundice (yellow)	Cyanosis (blue)
Congenital anomalies?	

CHILDHOOD YEARS 0-17 years (Please check all that apply)

Recurrent childhood illness	Serious falls	Active in sports
Car accidents	Surgery/stitches	Alcohol/drug abuse
Smoker	Antibiotics/medications	Vaccinations
Broken bones	Severe emotional distress	Under chiropractic care
Growing pains	Other	

ADULT YEARS 18 years and up (Please check all that apply)

Present smoker	Former smoker	OTC/Prescription meds
Alcohol use	Surgery/stitches	Play sports
Car accident(s)	Work injury	High stress job
High personal stress	Sit a lot	Drive a lot
Poor sleep	Not enough sleep	Poor/inadequate diet
No exercise	Flat feet	Wear orthotics/lifts
Severe health problems	Hard falls	Broken bones
Other		

Have you been under chiropractic care in the past? If so, how long ago was your last adjustment?

FEMALES ONLY: Are you pregnant?

Yes No
Date of last period

VACCINE HISTORY (Please check all that apply)

Prolonged Fever	Lethargy High Pitch Scream	Coma
Behavior changes	Rash	Muscular weakness
Breathing problems	Other	

HAVE YOU (YOUR CHILD) SUFFERED FROM: (Please check all that apply)

Dizziness	Backaches	Torticollis
Chronic earaches	Asthma	Allergies
Colic	Sinus problems	Diarrhea
Fainting	Convulsions	Paralysis
Bed wetting	Eye problems	Muscle jerking
Poor appetite	Headaches	Colds/Flu
Digestive Disorders	Leg problems	Growing pains
Arm problems	Joint problems	Behavioral problem
Walking problems	Speech problems	Cerebral Palsy
Autism	Epilepsy/Seizures	Scoliosis
Hyperactivity ADD/ADHD		
Other		

Clarifying Your Health Objectives

In addition to the main reason for your visit today, what additional health objectives do you have for your future?

Are you as healthy today as you were 5 years ago?

Yes No Not sure

Will you be as healthy as you are today 5 years from now?

Yes No Not sure

Major surgery/operations:

Broken bones

Major accidents/falls

Motor vehicle accidents

Medications

Hospitalization

Previous chiropractic care

Family History

Please indicate if yourself or which family member have/had any of the following conditions:

Do you know your family history? Yes No

Alcoholism

Genetic Diseases

Anemia

Glaucoma

Anesthesia Problem

Allergies

Anesthesia Problem

High Cholesterol

Arthritis

Asthma

Heart Disease (heart attack, stent, bypass surgery)

Birth Defects

High Blood Pressure

Cancer, Type

Kidney Disease

Migraine Headaches

Osteoporosis

Rheumatoid Arthritis

Tuberculosis

Seizures

Strokes

Thyroid Disorders

Colon Polyps

Depression

Diabetes, Type 1

Diabetes, Type 2

Other

Social History

Tobacco Use

I have smoked Never Occasionally Regularly

When was the last time you smoked?

Date that you quit smoking

How many packs per day

How many years have you smoked?

Other tobacco (pipe, cigar, snuff, chew, vape)

Would you like to quit smoking?

Alcohol Use

Do you drink alcohol? Yes No

Average # drinks per week

Is alcohol use a concern for you or others? Yes No

Drug Use

Do you use recreational drugs? Yes No

Have you ever used needles? Yes No

Most of your life, have you been more: Assertive Compliant Withdrawn

Most of your life, have you been driven more by: Fear Anger Image

Sexual History

Are you sexually active? Yes No Not currently

Birth control method:

Have you ever had any sexually transmitted diseases (STDs)? If so, which STD and when?

Exercise

Do you exercise? Yes No

How often do you exercise? Daily 4-6x per week 1-3x per week

What form of exercise?

Socioeconomics

Marital status: Single Married Separated Divorced
Widow

Occupation

Education completed grade school high school college
graduate school

Number of children

Who lives at home with you?