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

Married   Single   Divorced

Widowed

SPOUSE'S NAME

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?				