Personal and Family Health History

Date: ______________

Name _______________________________________

Address _____________________________________

City ____________________ State ____ Zip ________

Phone: (H) _______________ (W) ________________

Cell: __________________email: -________________

Date of Birth _______________ (Age ______)

Referred By __________________________________

Social Security # ______________________________

Occupation ___________________________________

Employer ____________________________________

Marital Status S M D W

Spouse's Name _________ Date of birth___________

Spouse's Occupation ____________________________

Number of Children and Ages

Name ____________________________ Age _____
Name ____________________________ Age _____
Name ____________________________ Age _____
Name ____________________________ Age _____

Previous Chiropractic Care?

Yes___ No___ Reason ____________________________
Yes___ No___ Reason ____________________________
Yes___ No___ Reason ____________________________
Yes___ No___ Reason ____________________________

Circle all that Apply	***Patient***	***Chiropractor's Comments***
Was Your Birth Traumatic?	Y	________________________________
Growth and Development		
Childhood sickness?	Y	________________________________
Have any Accidents?	Y	________________________________
Have Surgery? organs replaced/removed?	Y	________________________________
Take Drugs?	Y	________________________________
Experience other traumas?	Y	________________________________
Current Health Habits		
Smoke	Y	________________________________
Drink	Y	________________________________
Exercise regularly?		
Do you eat healthy foods?	Y	________________________________
Eye Problems?	Y	________________________________
Hearing Problems?	Y	________________________________
Sleeping problems? (nightmares)?	Y	________________________________
Occupational / mental stress?	Y	________________________________
Physical stress?	Y	________________________________
Sports injuries?	Y	________________________________
Sleeping posture – side–stomach–back		________________________________

Current Health Condition

Present Complaint (be brief) Reason For Your Visit Today: Pain Started on: _____________________________

____

Pain is: ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent Pain today is: 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition/pain? ____

What activities lessen your condition/pain? ____

Is condition worse during certain times of the day? ____

over

Is this condition interfering with work? ______ Sleep? ______ Routine? ______ Other? ______________________

Other Doctors seen for this condition ____

Any home remedies? ____

What vitamins supplements do you take: ____

____

What medications do you take?: ____

____ ______________________________________

What side effects have you experienced from medications: ____

Other symptoms:

❐ Headaches	❐ Face Flushed	❐ Light Bothers Eyes	❐ Feet Cold
❐ Neck Pain	❐ Neck Stiff	❐ Loss of Memory	❐ Hands Cold
❐ Sleeping Problems	❐ Pins & Needles in Legs	❐ Ears Ring	❐ Stomach Upset
❐ Back Pain	❐ Pins & Needles in Arms	❐ Fever	❐ Constipation
❐ Nervousness	❐ Numbness in Fingers	❐ Fainting	❐ Loss of Balance
❐ Tension	❐ Numbness in Toes	❐ Cold Sweats	❐ Buzzing in Ear
❐ Irritability	❐ Shortness of Breath	❐ Loss of Smell	
❐ Chest Pains	❐ Fatigue	❐ Loss of Taste	
❐ Dizziness	❐ Depression	❐ Diarrhea	

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other ______________
Father's Side	❐	❐	❐	❐	❐
Mother's Side	❐	❐	❐	❐	❐

What results do you hope to obtain in our office? (**Check all that apply**)

___ **Relief Care**: Relief from pain and symptoms to be more comfortable.

___ **Corrective Care:** Go beyond relief from pain and correct the problem at its source.

___ **Wellness Care**: Maintain the care you've received. Focus on your health, wellness and prevention.

Please rate your level of commitment to achieving your wellness goals:

1 2 3 4 5 6 7 8 9 10

Not at all **Complete**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Pinkus Family Chiropractic will prepare any necessary reports and forms to assist me in making collections from my insurance company and that any amount authorized to be paid directly to Pinkus Family Chiropractic will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable. I agree that I will be responsible for all attorney and legal fees if legal action becomes necessary to collect this account.

Patient's Signature:____ Date: ________________________________