

Health History

Contact Information

Name, Address, City, State, Zip, Birth Date, Home #, Work #, Ext., Beeper/Cellular, Fax, E-MAIL ADDRESS

Occupation, Employer, Employer's Address, City, State, Zip Code

Single, Married/Partnered, Divorced, Widowed, Name of Spouse, # of Kids, Names and ages of Kids

Main reason for consulting our office today?

Have you had chiropractic care in the past (circle one)? YES NO If yes, how long ago?

Who may we thank for referring you to our office?

YOUR HEALTH PROFILE

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

Mother smoked/drank/drugs in pregnancy, Epidural/Meds in labor, Breech Delivery, Forceps/ Vacuum Extractor Delivery, Labor Induced, C-Section Delivery, Premature/Overdue, Complications, Very Short Labor, Very Long Labor, Other

Childhood Years (Age 0-17 yrs)

Recurrent Childhood Illness, Active in Sports, Car Accident(s), Surgery/Stitches, Alcohol/Drug Abuse, Smoker, Antibiotics/Other Medications, Broken Bones, Severe Emotional Stress, Under Chiropractic care, Braces, Serious Falls, Other

Adult Years (Age 18 to present)

Present/Former Smoker, Braces, OTC/Prescription Meds, Alcohol Use, Surgery/Stitches, Play Sports, Car Accident(s), Work Injury, High Job Stress, 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 Injuries

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE NOW OR HAVE HAD IN THE PAST:

- | | | | |
|---------------------------------------|---|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Influenza | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eczema | <input type="checkbox"/> Malaria | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Goiter/Thyroid | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Chorea | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Whooping Cough |

Check any of the following you now have or have had previously:

GENERAL

- Allergy
- Convulsions
- Dizziness/Fainting
- Fatigue
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Depression
- Tremors

PAIN/NUMBNESS

- Low back
- Neck
- Mid-back
- Shoulders/arms
- Hands
- Hips/legs
- Ankles/feet
- Tailbone

MUSCLE/JOINT

- Arthritis
- Bursitis
- Disc problem
- Fibromyalgia
- Chronic sprain

- TMJ problems
(ie. Grinding, clicking,
etc.)

RESPIRATORY

- Chest pain
- Chronic cough
- Difficult breathing
- Wheezing
- Asthma
- Hay fever

G.I.

- Excessive belching
- Excessive gas
- Indigestion, heartburn
- Poor appetite
- Colitis or other colon
problems
- Constipation

- Diarrhea
- Gallbladder problems
- Hemorrhoids

GENITO-URINARY

- Kidney problems
- Frequent
urination/Excess thirst
- Bed-wetting

- Prostate problems

EENT

- Enlarged thyroid
- Eye pain
- Failing vision
- Far/near sightedness
- Ear pain/other
- Nasal symptoms
- Tonsillitis
- Other

WOMEN ONLY

- Menstrual or mid-
cycle cramps
- Heavy flow
- Hot flashes
- Menopausal symptoms
- Irregular cycle
- Lumps in breast
- Pelvic pain
- Menopause

CARDIOVASCULAR

- Hardening arteries

- High blood pressure
- Low blood pressure
- Poor circulation
- Rapid/irregular beat
- Swelling of ankles

SKIN

- Bruise easily
- Hives or allergy
- Itching
- Skin rash
- Eczema or psoriasis
- Varicose veins

LIFESTYLE QUESTIONS

ENGLANDER CHIROPRACTIC CENTER

SLEEP

Average # hrs. sleep per night _____ Position _____

Pillows _____

Good Quality? [] Yes [] No If no, why not?

EXERCISE

Do you do any regular structured exercise? [] Yes [] No

If Yes, what kind and how often? _____

WATER

8 oz. glasses of *plain water* per day _____ Source: [] Bottled [] Tap [] Filtered Other beverages (list types and # per day) _____

Do you add or use artificial sweeteners? [] Yes [] No Which one(s)? _____

FOOD

meals per day ____ If < 3, which one(s) do you skip? _____

Servings per day: Fruit _____ Veggies _____ Whole Grains _____ Dairy _____

Meats (beef, pork, poultry, seafood) _____ Sweets (all) _____

times per week food bought out (including cafeteria) _____

Do you take nutritional supplements? [] Yes [] No Please list what you take

WORK

Occupation _____ Hours/wk Sitting ____ standing ____ at a computer ____

Hours in car per day _____ Do you use a support in the car? [] Yes [] No

Do you travel with your job? [] Yes [] No

If yes, how often and for how long? _____

Please *briefly* describe your duties:

Do you like your present job? [] Yes [] No [] It's "OK"

If time, money, schooling, etc., did not matter, and you could be assured of making a good living, would you still do the job you're doing now? [] Yes [] No

If no, what would you do instead (i.e., what is your *fantasy* job)?

TOXICITY

Do you smoke? [] Yes # Packs/day ____ [] No [] Former When did you quit? _____

drinks of alcohol per week ____ Personal history of drug/alcohol abuse? [] Yes [] No

Please list any medications you take (OTC or Prescription) and what they are for

Have you *ever* taken oral or I.V. antibiotics? [] Yes [] No If so, was acidophilus also taken or have you taken it since then? [] Yes [] No [] Not Sure

STRESS

Please rate your *overall* level of stress, 0 to 10 (10 = high) _____
Now, at work/school _____ at home _____

- Please rate each category for stress, 0 to 10 (10 = high)
- _____ Personal relationships (spouse, family, friends, etc.)
 - _____ Work/business relationships
 - _____ Your job itself
 - _____ Finances
 - _____ Health
 - _____ Uncertainty of the future
 - _____ Other (Please explain)

PEACE

Do you do any deep breathing exercises regularly? [] Yes [] No
Do you take time to relax or meditate regularly? [] Yes [] No How? _____
How often? _____ For how long? _____
Do you do anything specific on a regular basis to encourage a positive mental attitude?
[] Yes [] No What? _____
Do you keep a journal? [] Yes [] No How often? _____

How happy are you 0 to 10 (10 = very happy) _____
If you could change just *one thing* in your life to raise your number just 1 higher, what would it be?

What is your main goal in coming here? _____

Why is that important to you (i.e., how will your life be better and what will you do once this is accomplished)?

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge.

I agree to allow the doctor to perform an assessment on me in order to make as complete an evaluation as possible.

SIGN _____

DATE _____
