HEALTH AND HISTORY ASSESSMENT

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NAME:_____ TODAY'S DATE: ____/___/___ SEX: M / F ACCT #: _____

ADDRESS: _____CITY:_____STATE:_____ ZIP: _____

HOME PHONE: (____)_____BUSINESS PHONE: (____)_____ CELL PHONE: (____)_____

PAGER: (____)_____ EMAIL ADDRESS: _____@_____

HEIGHT: _____ WEIGHT: _____ RT/ LT HANDED BIRTHDATE: ___/____/____ MARITAL STATUS: S M W D

SOCIAL SECURITY #: _____ EMPLOYER:_____

OCCUPATION: _____ HOW DID YOU HEAR ABOUT OUR OFFICE?:_____

DO YOU HAVE INSURANCE: Yes/No

1. What is your main concern?: _____
2. How long have you had this condition?: _____
3. Have you lost work days: Yes/No How many?_____
4. Have you been experiencing any activity restrictions? (check all that apply)

___ Lifting ___Standing ___ Personal Grooming ___Sleeping ___Social Life ___Driving

___ Sitting ___ Bending ___ Kneeling/Climbing ___Walking ___Sexual Activity ___In/Out of Vehicle

5. Was the injury related to: Work Accident Yes/No Auto Accident Yes/No Other Yes/No Please explain:_____

Describe what you feel caused this condition: _____

_____

6. When did you last see a chiropractor? _____Dr: _____

Why did you see this chiropractor? _____ Were you helped? Yes/No

What spinal maintenance programs were you given to follow to maximize the future stability of your spine? _____

Did you follow it? : Yes/No If no, why? _____Why are you changing Chiropractors? _____

A.
__ Fractured Bones
__ Auto Accidents
__ (a) - 0-1 years ago
__ (b) - 1.5 years ago
__ (c) - More than 5 years ago
__ Other Accidents/Falls
__ Knocked Unconscious
__ Back Curvature
__ Mental or Emotional Disorders
__ Arthritis
__ Diabetes
__ Swollen or Painful Joints
__ Convulsions/Epilepsy
__ Skin Problems
__ Bruise Easily
__ Cancer
__ Frequent Colds/Flu
__ Itching

B.
__ Nervous
__ Tension
__ Depressed
__ Irritable
__ Anemia
__ Excess Sweating – Tremors
__ Light Bothers Eyes
__ Sinus Problems
__ Allergy
__ Light Headed upon Rising
__ Under Stress
__ Crave Sweets or Salt
__ Eating Disorders

C.
__Trouble Sleeping
__Trouble Concentrating
__ Loss Of Memory
__ Learning Disabilities
__ Mistake Sides R/L
__ Stutter
__ Dyslexia
__ Mood Change
__ Lose Temper Easily

D.
__ Headache
__Neck Pain
__ Numbness, tingling, or pain in __ arms__Hands__fingers R/L
__ Jaw pain or click R/L
__ Heads seems to heavy
__ Hip pain R/L
__ Head & Shoulders feel tired
__ Difficulty in excessive (sitting, standing, walking, riding bending, and lifting)
__Shoulder Pain R/L
__ Foot trouble R/L
__ Dizziness
__ Ringing in Ears R/L
__ Hearing Loss R/L
__ Fainting
__ Blurred or double vision R/L
__ Upper back pain or arthritis R/L
__ Mid back pain or arthritis R/L
__ Lower back pain or arthritis R/L
__ Numbness, tingling or pain in buttocks, thighs, legs, feet,
__ Loss of Balance toes R/L
__ Pain with cough, sneeze or strain at stools

E.
__ Chest pain
__ Asthma
__ Lung problems
__ Difficult Breathing
__ Wheezing
__ Heart Problems
__ Stroke
__ High or low blood pressure
__Varicose Veins
__ Liver Trouble
__ Gall Bladder trouble

F.
__ Digestive problems
__ Excessive Gas
__ Belching/bloating after meals
__ Heartburn
__ Ulcers
__ Diarrhea/constipation
__ Colon trouble
__ Hemorrhoids
__ Prostate problems
__ Impotence

G.
__ Kidney trouble
__ Kidney stones
__ Frequent urination
__ Discharge
__ Menstrual problems/PMS
__ Menstrual problems
__Breast: lumps, soreness discharge
__ Pregnant (now)
__ Bed wetting
__ Ear infections
__ Hepatitis
__ Venereal Disease
__ AIDS/HIV
__ Other _____

7. Why did you come into our clinic and what are your expectations of us? _____
_____

8**. SOCIAL HISTORY**:

What are your favorite hobbies or activities to do now?: _____
Are your current problems affecting these activities or hobbies?: Yes/No
Do you take nutritional supplements? Yes/No If yes, describe:_____
Are you on any special diets? Yes/No If yes, describe: _____
Are you currently wearing: ___ Heel Lifts ___ Arch Supports
Do you smoke? Yes/No If yes, indicate number of packs a day: - Under 1__ 1__2 __ 3__ or more
Do you exercise? Yes/No If yes, describe: _____
Do you drink: __ Coffee __Tea __ Alcoholic beverages __ Soda If checked, how often _____
Do you sometimes feel that you do not have enough energy to get through the day? Yes/No

9. **FAMILY HISTORY** (please check those diseases that have affected you or your family) :

__ Heart disease	__Epilepsy	__Asthma	__Sinus problems
__Tuberculosis	__Anemia	__Retardation	__Other
__Cancer	__Diabetes	__HIV pos (AIDS)	
__Psychiatric	__Kidney disease	__High blood pressure	
__Overweight/Obesity	__Anorexia/Bulimia	__Circulatory Problem	

10. List all previous illnesses, injuries and hospitalizations/operations:

Area of body/Symptoms	Date	Describe (include any medication)
_____	_____	_____
_____	_____	_____
_____	_____	_____

11. Are you currently being treated by another doctor? Yes/No
If yes, Whom? _____ Why?_____
12. Are you currently taking any over the counter or prescription medication? Yes/No
If yes, What?_____ Why? _____
Name of Medication: _____ Taking for? _____
Name of Medication: _____ Taking for? _____
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Name of Medication: _____ Taking for? _____

I WILL BE PAYING BY:____CASH ____INSURANCE ____MEDICARE ____OTHER
If insurance, Name: _____Policy **#**_____

I certify this information to be true and correct. I assign my benefit payments to be paid directly to the **L.I.F.E. Chiropractic Center**; however, I understand that I am ultimately responsible for payment of service rendered. I also authorize the release of any information which is required for payment. Furthermore, I understand that the **L.I.F.E. Chiropractic Center** is not claiming to be a cure-all for my symptoms, and there are no guarantees.

_____ _____ _____
Patient or Guardian Signature Date Witness

Please feel free to discuss our fees. Fees are payable when services are received unless special arrangements are made in advance.