George’s Chiropractic Health Center

Personal & Family Health History Date_______ Account #______

Practice Member Auto Worker’s comp Medicare College Child

Name____ Referred by____________________

Address____City___________________ Zip_______

Phone (H) ______________________ (W) _____________________ (C) ____________________

E-Mail ____ SS# ________________________

Date of birth_________ Age ____ Sex M F Marital status S M D W Significant Other

Occupation:___________________Employer____

Spouse/Significant other’s name ____

Spouse/Significant other’s occupation_________________ Employer _____________________

Name of children & ages Any previous chiropractic care?

1st _______________________ Age _____ Y N Reason_________________________

2nd _______________________ Age _____ Y N Reason_________________________

3rd _______________________ Age _____ Y N Reason_________________________

Have you ever been to a chiropractor before? Y No Results? _______________________

Financial responsibility for care is? You Auto insurance Worker’s compensation

You deserve to be healthy and have a good Quality of Life. Life is a miracle and so are you. When you were created, you were given all the blueprints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause distortion to your health expression called the vertebral subluxation complex. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the Quality of Life you deserve.

Birth Process?	***Please check the box if the question pertains to you or your family.***				
Long delivery?	You	Spouse	Child #1	Child #2	Child #3
Difficult delivery?	You	Spouse	Child #1	Child #2	Child #3
Forceps?	You	Spouse	Child #1	Child #2	Child #3
Caesarian?	You	Spouse	Child #1	Child #2	Child #3
Breach/cephalic?	You	Spouse	Child #1	Child #2	Child #3
Home birth?	You	Spouse	Child #1	Child #2	Child #3
Induced labor?	You	Spouse	Child #1	Child #2	Child #3

Growth & Development	***Please check the box if the question pertains to you or your family.***			
Fallen out of bed?	You	Spouse	Child #1	Child #2	Child #3
Head injuries?	You	Spouse	Child #1	Child #2	Child #3
Spine injuries?	You	Spouse	Child #1	Child #2	Child #3
Experience surgery?	You	Spouse	Child #1	Child #2	Child #3
Take medications?	You	Spouse	Child #1	Child #2	Child #3
Experienced child abuse?	You	Spouse	Child #1	Child #2	Child #3
Fallen down the stairs?	You	Spouse	Child #1	Child #2	Child #3
Ride bumping cars?	You	Spouse	Child #1	Child #2	Child #3
Ever unconscious?	You	Spouse	Child #1	Child #2	Child #3
Any broken bones?	You	Spouse	Child #1	Child #2	Child #3

Current Health Habits	***Please check the box if the question pertains to you or your family.***				
Do you smoke?	You	Spouse	Child #1	Child #2	Child #3
Have a poor diet?	You	Spouse	Child #1	Child #2	Child #3
Use artificial sweeteners?	You	Spouse	Child #1	Child #2	Child #3
Organs removed?	You	Spouse	Child #1	Child #2	Child #3
Had surgeries?	You	Spouse	Child #1	Child #2	Child #3
Taking medication?	You	Spouse	Child #1	Child #2	Child #3
Take yearly flu shots?	You	Spouse	Child #1	Child #2	Child #3
Do you exercise?	You	Spouse	Child #1	Child #2	Child #3
Have occupational stress?	You	Spouse	Child #1	Child #2	Child #3
Have family stress?	You	Spouse	Child #1	Child #2	Child #3
Have mental stress?	You	Spouse	Child #1	Child #2	Child #3

Current Health Condition

Reason for today's visit? ____

Problem started on ____________ Have you had this symptom before? Y N

How long have you had this symptom? Days Weeks Months Years

What activities aggravate your condition? Standing Walking Sitting Bending Twisting Other_________________

Is condition worse at different times of the day? AM PM Sleeping

Condition interfering with work? Y N Sleep? Y N Daily Routine? Y N

Condition progressively getting worse? Y N Same

Other doctors seen for this problem? Y N Who? ______________________________

Other Symptoms in the last 30 days or since accident: please check

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	Fevers	Constipation
Tension	Numbness in fingers	Fainting	Diarrhea
Irritability	Tightness between shoulders	Numbness in toes	Cold sweats
Chest pains	Fatigue	Balance	High blood pressure
Dizziness	Depression	Bowel problems	Low blood pressure
Sinus	Shortness of breath	Moods swings	Allergies

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What surgeries have you had? ____

____

If you are taking medications, what symptoms are you treating?___________________________

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How many car accidents even if they were minor? _______ List each year of accidents.
___________________Rear end _________________ Broadside _______________Head on

If you could get rid of one symptom today, maybe the symptom that brought you into our office today or another symptom; to eliminate that symptom out of your life forever, the one symptom that affects your lifestyle the most, WHAT WOULD IT BE?____

When that symptom is at its absolute worse, how does it make you feel?

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If you could get rid of this symptom, what would your commitment be from 1 through 10, 10 being the highest commitment, 1 being the lowest commitment? ***Circle*** 1 2 3 4 5 6 7 8 9 10 ______

As a result of my chiropractic care, I would like to or have: (Please check all that apply)

Symptom Relief	More Energy	Become more active	Healthier Spine
Healthier Body	Healthier Lifestyle	Better Quality of Life	Increased Human Potential

What type of care do you want?

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak. This care is not recommended because the health problem is never handled, and your health problem progressively gets worse over time.

Corrective Care to correct the problem by addressing the cause of why your body may not be healing, adapting or repairing which is controlled by your nerve system. Corrective care varies in length of time, but is more lasting and improves the overall health of a person. Corrective and stabilization care goals are to enhance your Quality of Life. This care is recommended by George's Chiropractic Health Center.

Not Sure what kind of care I want.

____ Date_______________

Practice Member's Signature or Guardian

Do Not Write Below This Line ***Do Not Write Below This Line***

Spinal X-rays Y N Cervical Motion X-rays Y N Pregnant Y N

Trigger Points Results:____

Video Response Excellent Good Fair Poor Not Seen It

1st Adjustment Response____

2nd Adjustment ____

Date of Quality of Life Workshop. ________ Spouse Significant Other Parent Y N

Date of Report of Findings. _________ Spouse Significant Other Parent Y N

Ask spouse/significant other/parent, what they have heard or know about chiropractic.

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Is Spouse, Significant Other, or Parent supported? Y N

Remarks ____