Whole Health
CHIROPRACTIC

_____ / _____ / _____

HEALTH HISTORY QUESTIONNAIRE

Title:_____ Name:_____
❑Male ❑Female Date of Birth: _____ Age: _____
Address:_____
City/State/Zip:_____
Telephone: (Home)_____ (Work)_____
(Mobile)_____ E-mail:_____
Spouse/ Next of kin: _____
Marital Status: Single / Married / Other

Children: Names (age) _____ ( ) _____
( )_____( )_____( ) _____
Occupation: _____
How did you hear about us? _____
Have you seen a Chiropractor before: ❑Yes ❑No
If so when:_____ Name of chiropractor:_____
Referred by: (name)_____ Family / Friend
Co-Worker / Doctor / Google / Yelp / Facebook / Other

It is a pleasure to welcome you to Whole Health Chiropractic. Throughout life, events occur which can compromise your level of health and wellbeing. Please complete the following case history, which is designed to help uncover any events, especially to your spine and nerve system, that have resulted in poor health. Following your examination today, at your next visit, your chiropractor will outline a course of care to optimize your health potential.

HEALTH OBJECTIVES & CURRENT CONCERNS

People consult this practice with varied health objectives. Please indicate which apply to you.

❑ **Relief of symptoms** ❑ **Correction of my underlying problems**
❑ **Better perform work or recreational activities** ❑ **To improve my health and enhance my quality of life**

How do you grade your current physical health? *(please circle)* worst 1 2 3 4 5 6 7 8 9 10 best
How do you grade your current mental/emotional health? *(please circle)* worst 1 2 3 4 5 6 7 8 9 10 best

My main reason for consulting WHC today is: _____
Describe WHEN and HOW this began:_____
Grade Intensity/Severity of Complaint: None (0) / Mild (1-2) / Mild-Mod (2-4) / Moderate (4-6) / Mod-Severe (6-8) / Severe (8-10)
Quality of the complaint/pain: Sharp / Stabbing / Burning / Achy / Dull / Stiff and Sore/Other:_____
How Frequent is the complaint present? Off and On / Constant
Does this complaint radiate/shoot to any areas of your body? No / Yes (*Describe*) _____
Does anything make the complaint better? Ice / Heat / Rest / Movement / Stretching / OTC / Other: _____
Does anything make the complaint worse? Sit / Stand /Walk / Lying / Sleep / Overuse / Other: _____
Which daily activities are being affected by this condition? (*Describe*) _____
Do you have any other health concerns?_____
How do you feel it might it affect you if you do not improve your current level of health?
_____

HEALTH REVIEW

Please indicate if any of the following apply to you either in the past (P) or currently (C).

P	C		P	C		P	C		P	C	
❒	❒	Headaches/Migraine	❒	❒	Depression/Anxiety	❒	❒	Chronic Cough	❒	❒	Change in Appetite
❒	❒	Ears Ringing/Buzzing	❒	❒	Poor concentration	❒	❒	Heart Problems	❒	❒	Difficulty swallowing
❒	❒	Scalp Tenderness	❒	❒	Moody/Irritable	❒	❒	Chest pain	❒	❒	Dizziness/Fainting
❒	❒	Numbness/Burning	❒	❒	Loss of Memory	❒	❒	Digestive Problems	❒	❒	Weight change
❒	❒	Tingling/Pins& Needle	❒	❒	Sleeping Problems	❒	❒	Constipation/Diarrhea	❒	❒	Skin changes
❒	❒	Loss of Strength	❒	❒	Allergies/Hay fever/Sinus	❒	❒	Nausea/Vomiting	❒	❒	Bed-wetting
❒	❒	Excessive Fatigue	❒	❒	Breathing problems/Asthma	❒	❒	Loss Smell/Taste	❒	❒	Night pain/sweat

Do you have a family history of: ❒ Hypertension ❒ Stroke ❒ Heart Attack ❒ Arthritis ❒ Cancer ❒ Diabetes
❒ Other:_____

Compromised health may result from the body's inability to adapt to stresses experienced through life. Physical stresses include traumas (knocks, bumps, falls, posture, sporting injuries etc), emotional stresses include thoughts (mental, emotions, attitudes, state of mind etc) and Chemical stresses include toxins (food, drugs, air, alcohol, tobacco, environment etc).

LIFE HISTORY: BIRTH - AGE 5

Often the cause of our health problems begin in our early years.

Pregnancy

To the best of your knowledge did your mother…

Receive Chiropractic care during pregnancy: ❑Yes ❑No
Exercise during pregnancy: ❑Yes ❑No
Have a nutritious diet: ❑Yes ❑No
Have any illness during pregnancy ❑Yes ❑No
Receive any injuries during pregnancy: ❑Yes ❑No
Take any drugs, smoke or drink during pregnancy: ❑Yes ❑No
Endure stress during pregnancy: ❑Yes ❑No

Birth Process

Were you induced: ❑Yes ❑No
Were any drugs used during labour: ❑Yes ❑No
Was your delivery difficult: ❑Yes ❑No
Were you delivered with forceps or suction: ❑Yes ❑No
Were you delivered by caesarean: ❑Yes ❑No

Growth and Development

As an infant were you breastfed: ❑Yes ❑No
Did you take any medications: ❑Yes ❑No
Did you have any accidents: ❑Yes ❑No
Did you have any hospitalizations: ❑Yes ❑No
Did you have any surgery: ❑Yes ❑No
As a child were you vaccinated: ❑Yes ❑No

LIFE HISTORY: AGE 5-PRESENT

As the layer of damage increased you may have experienced symptoms and random bouts of sickness.

Chemical Stress

Have you been exposed to any chemicals: ❑Yes ❑No
Have you been exposed to dust, fumes, smoke ❑Yes ❑No
Have you, or are you taking any medications ❑Yes ❑No
If yes, please name:_____
Do/Did you smoke: ❑Yes #____ per day ❑No
Drink alcohol: ❑Yes #____ glasses day ❑No
Drink water: ❑Yes #____ glasses day ❑No
Drink sugary drinks: ❑Yes how often _____ ❑No
Drink tea/coffee: ❑Yes how often _____ ❑No
Eat sugary foods : ❑Yes how often _____ ❑No
Is your diet: ❑ Balanced ❑ Processed ❑ Organic ❑ Other
(Explain): _____

Physical Stress

Have you been in a Motor Accident: ❑Yes, When: ❑No
What happened: _____
Been knocked unconscious: ❑Yes, When: ❑No
If so, explain: _____
Other Accidents/Falls ❑Yes, When: ❑No
What happened: _____
Any Broken Bones: ❑ Yes, When: ❑No
If so, explain: _____
Any injuries to spine ❑ Yes, When: ❑No
If so, explain: _____

Any Hospitalizations: ❑ Yes, When: ❑No
If so, explain: _____
Any Surgery: ❑ Yes, When: ❑No
What type? _____
Have you ever suffered from chronic illness: ❑ Yes ❑No
If yes, explain: _____
Have you received any diagnosis before: ❑ Yes ❑No
If yes, explain: _____
Do you do any Repetitive or Prolonged activities ❑ Yes ❑No
If yes, explain: _____
Sleeping posture: ❑ Side ❑ Stomach ❑ Back
Hobbies/Recreation:_____
How often do you exercise: ❑Never ❑Rarely ❑Weekly
❑Daily What form of exercise: _____

Emotional Stress

Have you in the past, or do you currently experience:
Stress in the workplace: ❑ Yes ❑ No
Stress at school: ❑ Yes ❑ No
Stress with relationships: ❑ Yes ❑ No
Stress at home with family: ❑ Yes ❑ No
Have you suffered from any emotionally or mentally stressful event or crisis: (eg, Relationship, Family, Business, Financial)
❑ Yes ❑ No (If so, explain): _____
_____

CONSENT

The aim of chiropractic care at Whole Health Chiropractic is not to diagnose or treat disease, but to get to the cause of your health problems and help correct them. This is done through natural means, without the use of drugs or surgery. I understand this and consent to a thorough chiropractic examination including spinal nerve scans. I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: _____ Date: _____ / _____/ _____