

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