HEALTH FIRST
CHIROPRACTIC & WELLNESS

OUR MISSION:
TO CREATE ENERGETIC AND INSPIRED LIVING BY PROVIDING WORLD-CLASS CHIROPRACTIC AND WELLNESS CARE IN ALL DIMENSIONS OF LIFE.

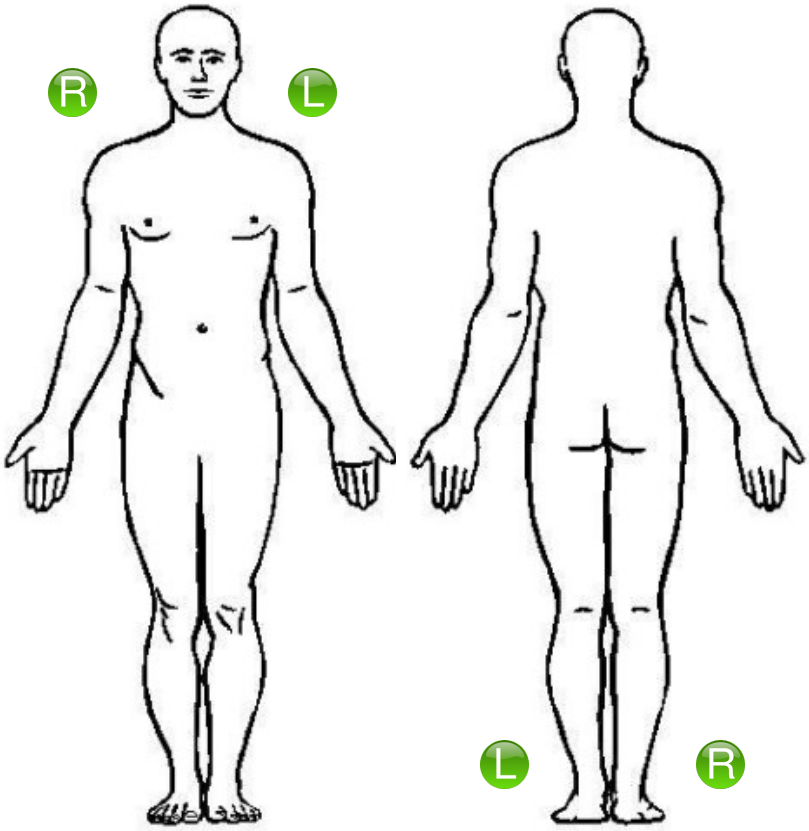
PATIENT INFORMATION (PLEASE PRINT)

NAME _____ **TODAY'S DATE** ____/____/____
STREET ADDRESS _____
CITY _____ STATE _____ ZIP _____
CELL # _____ DAYTIME # _____ EVENING # _____
EMAIL _____ DOB ____/____/____ CIRCLE ONE MALE FEMALE
NUMBER OF CHILDREN _____ NAMES & AGES _____

MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED
EMERGENCY CONTACT PERSON _____ PHONE# _____
EMPLOYER _____ OCCUPATION _____
HOW DID YOU HEAR ABOUT OUR OFFICE (CIRCLE ONE) WEBSITE INSURANCE CARRIER INTERNET SEARCH LOCATION
REFERRED BY _____ OTHER _____

INSURANCE INFORMATION:
INSURANCE CARRIER _____ POLICY NUMBER _____
INSURED EMPLOYER _____ RELATIONSHIP TO INSURED (CIRCLE ONE) SELF SPOUSE CHILD

THE REASON FOR THIS VISIT IS A RESULT OF (please circle) AUTO WORK FALL SPORTS CHRONIC SPINAL WELLNESS CHECK UP OTHER _____
PLEASE DESCRIBE YOUR **MAJOR COMPLAINT** AND HOW IT HAPPENED _____



DATE STARTED_____/_____/_____HAD BEFORE? Y N
PLEASE DESCRIBE _____

IS THIS INTERFERING WITH YOUR (please circle)
SPORTS RECREATION OTHER
IF SO, PLEASE EXPLAIN _____

ON THE DIAGRAM TO THE LEFT, PLEASE INDICATE WHERE YOU ARE EXPERIENCING PAIN OR SYMPTOMS BY CIRCLING THE AREA AND THEN PLACING THE LETTER LISTED BELOW THAT CORRESPONDES TO YOUR BODYS WARNING SIGNALS.

ABBREVIATIONS ON THE DIAGRAMS

SHARP PAIN = P	**DULL PAIN = D**
STIFFNESS = S	**NUMBNESS = N**
TINGLING = T	**BURNING = B**

IF PAIN RADIATES FROM ONE LOCATION TO ANOTHER, PLEASE **DRAW A LINE** IN THE AREA YOU ARE EXPERIENCING IT.

PLEASE LIST EACH AREA OF YOUR SYMPTOMS BELOW IN ORDER OF SEVERITY, AND THEN AT THE SCALE TO THE RIGHT, CIRCLE THE NUMBER THAT BEST REPRESENTS THE LEVEL OF SEVERITY. (O BEING NO PAIN AND 10 BEING THE MOST SEVERE IMAGINABLE)

AREAS OF SYMPTOMS **LEVEL OF SEVERITY** (CIRCLE ONE)

1. _____ 1 2 3 4 5 6 7 8 9 10
WHAT MAKES IT BETTER _____ WHAT MAKES IT WORSE _____
2. _____ 1 2 3 4 5 6 7 8 9 10
WHAT MAKES IT BETTER _____ WHAT MAKES IT WORSE _____
3. _____ 1 2 3 4 5 6 7 8 9 10
WHAT MAKES IT BETTER _____ WHAT MAKES IT WORSE _____

About your health…

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nervous system, that have resulted in your lowered state of health. At your report of findings, your chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

PRESENT HEALTH: Are you presently affected by any of the following? (Within past 3 months) **PLEASE CHECK ONE** ✓

O – Occassional F – Frequent C – Constant

Muscle and Joint	**O**	**F**	**C**
Backache			
Neck pain			
Painful tailbone			
Foot trouble			
Shoulder pain			
Hernia			
Spinal curvature			
Faulty posture			
Arthritis			

General Symptoms	**O**	**F**	**C**
Fever/Chills/Sweat			
Fainting			
Convulsions			
Allergy			
Skin problems			
Colds			
Tremors			
Loss of balance			

Cardiovascular	**O**	**F**	**C**
Rapid heart beat			
Slow heart beat			
High blood pressure			
Low blood pressure			
Pain over heart			
Swelling of ankles			
Previous heart attack			
Poor circulation			
Previous stroke			

Gastrointestinal	**O**	**F**	**C**
Difficult digestion			
Belching or gas			
Nausea or vomiting			
Pain over stomach			
Constipation			
Colon trouble			
Liver trouble			
Gall bladder trouble			
Heartburn			
Diarrhea			
Bloody stools			

Stress Symptoms	**O**	**F**	**C**
Headache/Migraine			
Dizziness			
Numbness or pins & needles in arms/legs/feet			
Ringing in ears			
Blurring of vision			
Loss of sleep			
Loss of concentration /memory			
Irritable/Nervousness			
Depression			
Decreased energy/fatigue			

Respiratory	**O**	**F**	**C**
Chronic cough			
Spitting up phlegm/blood			
Chest pain			
Difficulty breathing			

Eyes, Ears, Nose, Throat	**O**	**F**	**C**
Chronic cough			
Spitting up phlegm/blood			
Chest pain			
Difficulty breathing			

Females Only	**YES**	**NO**
Painful menstruation		
Excessive flow		
Irregular menstruation		
Cramps or backache		
Abnormal discharge		
Passed menopause		
Are you pregnant?		
Birth control pill?		

No. of miscarriages _____

Date of last menstrual period:

Urinary	**O**	**F**	**C**
Painful urination			
Getting up at night to urinate			
Blood in urine			
Increased urination			

Birth Difficulties	**YES**	**NO**
Forceps		
Vacuum		
C-Section		

PAST HEALTH: Have you ever suffered from any of the following conditions?

	Y	N
Thyroid trouble		
Diabetes		
High blood pressure		
Heart disease		
Allergies		

	Y	N
Tuberculosis		
Pneumonia		
Back pain		
Headaches		
Stomach ulcers		

	Y	N
Emotional problems		
Epileptic seizures		
Asthma		
Arthritis		
Alcoholism		

	Y	N
Psoriasis		
Polio		
Cancer		
Venereal disease		
HIV		

PLEASE LIST ANY SIGNIFICANT ILLNESS, OPERATIONS, ACCIDENTS, FALLS OR TRAUMAS

Date	Illness / Operation / Accident / Falls

INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients of benefits and risks including sprain/strain, rib fracture, disc herniation and with neck problems of the following: there have been extremely rare incidents of injury to the vertebral artery during the course of treatment. This has caused stroked or stroke like occurrences, which are usually of a temporary nature. The chances of this happening are less than one in ten million. Tests, without x-rays have been performed on you to minimize these risks to yourself. Chiropractic is considered to be one of the safest and most effective forms of therapy for neck conditions. If you have any questions about this, please ask your chiropractor. Please sign below if you read the above statement and consent to treatment.

Signature: _____ **Date Signed:** _____

Thank you for completing this form. We certainly hope that we can help you attain optimal health.