CHIROPRACTIC HISTORY

What would you like to gain from chiropractic care? ( )Resolve existing condition(s) ( ) Overall wellness ( ) Both

Have you ever visited a chiropractor? Y N If yes, what is their name?

What is their specialty? ( ) Pain Relief ( ) Physical Therapy & Rehab ( ) Nutritional ( ) Subluxation-based ( ) Other__________

Do you have any health concerns for any other family members today?

TRAUMAS: Physical Injury

Have you ever had any significant falls, injuries, or surgeries as an adult? ( ) Yes ( ) No If yes, Please explain.

Notable childhood injuries? ( ) Yes ( ) No If yes, Please explain

Youth or college sports? ( ) Yes ( ) No If yes, any injuries?

Any Auto accidents? ( ) Yes ( ) No If yes, please explain

Exercise Frequency? ( ) None ( ) 1-2 X week ( ) 3-5 X week ( ) Daily What type of exercise?

How do you normally sleep? ( ) Back ( ) Side ( ) Stomach Do you wake up : ( ) Refreshed and ready ( ) Stiff and tired

Do you commute to work? ( ) Yes ( ) No If yes, how many minutes a day?

List any problems with flexibility.

How many hours per day do you usually spend at a desk, computer, tablet or phone?

TOXINS: Chemical & Environmental Exposure

Please rate your consumption of each: (1=None, 5=High)

Alcohol	1 2 3 4 5	Processed Foods	1 2 3 4 5
Water	1 2 3 4 5	Artificial Sweeteners	1 2 3 4 5
Sugar	1 2 3 4 5	Sugary Drinks	1 2 3 4 5
Dairy	1 2 3 4 5	Cigarettes	1 2 3 4 5
Gluten	1 2 3 4 5	Recreational Drugs	1 2 3 4 5

Please list any drugs/medications/herbs/vitamins/other that you are taking and why:

THOUGHTS: Emotional stressors and challenges

Home	1 2 3 4 5	Money	1 2 3 4 5
Work	1 2 3 4 5	Health	1 2 3 4 5
Life	1 2 3 4 5	Family	1 2 3 4 5

Acknowledgement and Consent

Patient Name______________________________________ Date____