

CHIROPRACTIC SOLUTIONS HEALTH HISTORY FORM

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Please fill out this form as completely and accurately as possible.

Today's Date _____

PERSONAL DATA

Name _____ Age _____ Date of Birth _____

Parent's names (if you are under 18) _____

Home Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____ E-mail Address _____

Occupation _____ Employer _____

Marital Status S M D W Spouse/Partners Name: _____

Names and Ages of Children _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Chiropractic Solutions can address for you?

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

| | | | | | | | | |
|------------------|---|---|----------|---|---|----------|---|---|
| Work: | Y | N | Driving: | Y | N | Sleep: | Y | N |
| School: | Y | N | Walking: | Y | N | Sitting: | Y | N |
| Exercise/sports: | Y | N | Eating: | Y | N | Other: | Y | N |

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? Y N Name of D.C. _____

How long under care? _____ days _____ weeks _____ months years _____

Date of last visit: _____ Why did you stop? _____

How was your experience? _____

Have you consulted or do you regularly consult any of the following providers? (Check all that apply.)

Medical Physician Naturopath Acupuncturist Homeopath
 Massage Therapist Psychotherapist Energy Healer Dentist

Reason why: _____

FOR WOMEN

Are you pregnant? Y N Possible/Unknown

If pregnant due date? _____ Name of OBGYN or Midwife: _____

If x-rays are recommended, your signature is required to indicate that you are **not pregnant**.

Signature: _____ Date: _____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body, which coordinates health, is the CENTRAL NERVE SYSTEM. The vertebrae, the bones of the spinal column, surround and protect the delicate NERVE SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the SPINE AND NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL AND CHEMICAL stressors you have been subjected to and **how they may relate to your present spinal, nerve and health status.**

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine and nerve system. Please indicate where and how you were birthed. (If you do not know, please skip to next question.)

- | | | | | |
|---------------------------------|---|--|---|----------------------------------|
| <input type="checkbox"/> Home | <input type="checkbox"/> Natural | <input type="checkbox"/> Hospital | <input type="checkbox"/> Caesarian section | <input type="checkbox"/> Forceps |
| <input type="checkbox"/> Breech | <input type="checkbox"/> Cord around neck | <input type="checkbox"/> Prolonged labor | <input type="checkbox"/> Drug induced labor | <input type="checkbox"/> Suction |

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor, and often ignored, repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any **accidents or injuries in your life** related to any of the following? (Check all that apply.)

- | | | | | | |
|-------------------------------------|-------------------------------------|----------------------------------|---------------------------------|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Automobile | <input type="checkbox"/> Motorcycle | <input type="checkbox"/> Bicycle | <input type="checkbox"/> Sports | <input type="checkbox"/> Playground | <input type="checkbox"/> Abuse |
|-------------------------------------|-------------------------------------|----------------------------------|---------------------------------|-------------------------------------|--------------------------------|

If yes, state **type of injury and date:**

Have you ever **hurt/injured** your spine, head, neck, ribs, chest, upper or lower back, pelvis or hips? Y N

If yes, state **type of injury and date:**

Have you ever **hurt, broken, fractured or sprained** any bones or joints? Y N

If yes, list **body parts injured and dates:**

Have you ever been hospitalized? Y N

If yes, **state reason and dates:** _____

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

| | | | | | | | | |
|------------------|---|---|--------------------|---|---|-----------|---|---|
| Childhood trauma | Y | N | Loss of loved one | Y | N | Abuse | Y | N |
| Work or School | Y | N | Divorce/separation | Y | N | Financial | Y | N |
| Lifestyle change | Y | N | Parents divorce | Y | N | Illness | Y | N |

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you **vaccinated**? Y N If yes, did you have a **reaction**? Y N
Have you been **exposed to** any of the following on a regular basis, past or present?

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Toxic chemicals | <input type="checkbox"/> Second hand smoke | <input type="checkbox"/> Drug therapy |
| <input type="checkbox"/> Radiation | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Other |

If yes, please explain: _____

Do you have **allergies** to any foods? Y N **If yes, please list:** _____

Do you presently **consume** any of the following?

- Coffee/caffeine Alcohol Tobacco Over the counter drugs Prescribed drugs

Please list all medications, and ***specifically what condition or symptoms they were prescribed for*** :

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE

How do you grade your **physical health**? Good Fair Poor

How do you grade your **emotional/mental health**? Good Fair Poor

How do you rate your overall **"quality of life"**? Good Fair Poor

Do you **exercise** regularly? If yes, how often? _____

Do you take **supplements**? If yes, please list: _____

Do you follow a **special dietary regime**? If yes, what? _____

How would you rate the quality of your sleep? great moderate poor

On average, how much sleep do you get a night? _____

What position do you sleep in? (check all that apply) back side stomach

EXPECTATIONS

I would like to have the following benefits from **Chiropractic Care**: (Check all that apply)

- Relief of a symptom or problem
- Relief and prevention of a symptom or problem
- Healthier spine and nerve system
- Optimal health on all levels

CHIROPRACTIC CLINICAL OBJECTIVE

Physical, Emotional and Chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

Many common symptoms and conditions are caused by the interference and stress on the nerve system. Please place a (X) on conditions that you are currently suffering from and a (O) on any conditions you have had in the past.

- | | | |
|--|--|--|
| <input type="checkbox"/> Arthritis <input type="checkbox"/> Back Curvature <input type="checkbox"/> Mental / Emotional Disorders <input type="checkbox"/> Diabetes <input type="checkbox"/> Swollen or Painful Joints <input type="checkbox"/> Convulsions / Epilepsy <input type="checkbox"/> Skin Problems <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer <input type="checkbox"/> Allergies <input type="checkbox"/> Frequent Colds <input type="checkbox"/> Upper Back Pain / Stiffness <input type="checkbox"/> Excessive Gas <input type="checkbox"/> Constipation / Diarrhea <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Impotence <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Menstrual Problems / PMS <input type="checkbox"/> Menopausal problems | <input type="checkbox"/> Headache <input type="checkbox"/> Migraine Headache <input type="checkbox"/> Neck Pain R/L <input type="checkbox"/> Shoulder Pain R/L <input type="checkbox"/> Numbness or Tingling in arms, or hands R/L <input type="checkbox"/> Carpal Tunnel Syndrome R/L <input type="checkbox"/> Dizziness <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Digestive Problems <input type="checkbox"/> Depression <input type="checkbox"/> Attention Disorder <input type="checkbox"/> Anxiety Disorder <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Trouble Concentrating <input type="checkbox"/> Loss of memory <input type="checkbox"/> Ear Infection <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Asthma <input type="checkbox"/> Chest Pain <input type="checkbox"/> Difficult Breathing <input type="checkbox"/> Heart Problems <input type="checkbox"/> Heart Attack <input type="checkbox"/> Stroke <input type="checkbox"/> Bruit <input type="checkbox"/> High / Low Blood Pressure <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Liver Trouble <input type="checkbox"/> Gall Bladder Trouble <input type="checkbox"/> Mid Back Pain / Stiffness <input type="checkbox"/> Pain with cough, or strain <input type="checkbox"/> Hip Pain <input type="checkbox"/> Low Back Pain / Stiffness <input type="checkbox"/> Sciatica <input type="checkbox"/> Numbness or Tingling in legs or feet R/L <input type="checkbox"/> Muscle Tightness <input type="checkbox"/> Trouble sleeping |
|--|--|--|

Primary Health Concern: _____



- Please indicate the location of your pain or discomfort on the diagram
 When did this problem start? _____
 Have you ever had this problem before? No Yes
 If yes, when _____
 Please indicate quality of the pain:
 Dull Burning Numb Stabbing Tingling Cramping
 Does this pain radiate or travel? No Yes
 If yes, please indicate on diagram
 Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain)
 1----2----3----4----5----6----7----8----9----10
 What makes this pain or condition better? _____ Worse? _____
 What have you done to treat this problem? _____

Office Use Only:

Secondary Health Concern: _____



- Please indicate the location of your pain or discomfort on the diagram
 When did this problem start? _____
 Have you ever had this problem before? No Yes
 If yes, when _____
 Please indicate quality of the pain:
 Dull Burning Numb Stabbing Tingling Cramping
 Does this pain radiate or travel? No Yes
 If yes, please indicate on diagram
 Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain)
 1----2----3----4----5----6----7----8----9----10
 What makes this pain or condition better? _____ Worse? _____
 What have you done to treat this problem? _____

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