Wellness Chiropractic – JC Carpenter, D.C.

Personal and Family Health History

Date _____

Name_____
Please Print First Middle Initial Last
Address _____
City _____ State _____ Zip _____
Phone: (H) _____
(W) _____ (C)_____
E-mail _____
Date of Birth _____ (Age ____)
Social Security # _____
Marital Status S M D W

Employer _____
Name of Pry. Insurance_____
Spouse's Name _____
Spouse's Employer_____
Spouse's SS# _____DOB _____
Name of Sec. Insurance _____
Emergency Contact _____
Emergency Phone # _____
Referred By: _____

Number of Children and Ages

Previous Chiropractic Care?

Name _____ Age_____ Yes____ No____ Reason _____
Name _____ Age_____ Yes____ No____ Reason _____
Name _____ Age_____ Yes____ No____ Reason _____
Name _____ Age_____ Yes____ No____ Reason _____

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Circle all that Apply

	Patient	Spouse	#1	#2	#3
1. Was Your Birth Traumatic?					
Long Delivery?	Y	Y	Y	Y	Y
Difficult Delivery?	Y	Y	Y	Y	Y
Forceps?	Y	Y	Y	Y	Y
Caesarian?	Y	Y	Y	Y	Y
Breach/cephalic?	Y	Y	Y	Y	Y
Home birth?	Y	Y	Y	Y	Y
Mother given drugs during delivery?	Y	Y	Y	Y	Y
Induced Labor?	Y	Y	Y	Y	Y
2. Growth and Development, Did you ever once..					
Learn to care for your spine?	Y	Y	Y	Y	Y
Fall out of bed?	Y	Y	Y	Y	Y
Bang your head?	Y	Y	Y	Y	Y
Breastfeed?	Y	Y	Y	Y	Y
Childhood sickness?	Y	Y	Y	Y	Y
Have any Accidents?	Y	Y	Y	Y	Y
Have Surgery?	Y	Y	Y	Y	Y
Take Drugs?	Y	Y	Y	Y	Y
Fall while learning to walk?	Y	Y	Y	Y	Y
Bullied by your siblings?	Y	Y	Y	Y	Y
Chair pulled out when sitting?	Y	Y	Y	Y	Y
Fall down the stairs?	Y	Y	Y	Y	Y
Pulled by your arm?	Y	Y	Y	Y	Y
Experience other traumas?	Y	Y	Y	Y	Y

	Patient	Spouse	#1	#2	#3
3. Current Health Habits,					
Smoke?	Y	Y	Y	Y	Y
Drink? (alcoholic beverages)	Y	Y	Y	Y	Y
Diet? (eat healthy foods)	Y	Y	Y	Y	Y
Been in accidents?	Y	Y	Y	Y	Y
Had organs replaced/removed?	Y	Y	Y	Y	Y
Drugs? (Prescriptive/ non Rx)	Y	Y	Y	Y	Y
Have Teeth Problems?	Y	Y	Y	Y	Y
Have Eye Problems?	Y	Y	Y	Y	Y
Have Hearing Problems?	Y	Y	Y	Y	Y
Exercise regularly?	Y	Y	Y	Y	Y
Have sleeping problems?	Y	Y	Y	Y	Y
Have occupational stress?	Y	Y	Y	Y	Y
Have physical stress?	Y	Y	Y	Y	Y
Have mental stress?	Y	Y	Y	Y	Y
Have hobbies/sports injuries?	Y	Y	Y	Y	Y

Sleeping posture? (side, stomach, back) _____

Are you pregnant? Y N Due date _____
Have you seen a Chiropractor before? Y N
Doctor seen _____
Date of last visit _____
Previous issue _____
_____

Do you have a **pacemaker**? Y N

Have you had **surgery**? Y N What and when?

_____
_____

MEDICATIONS: _____ VITAMINS: _____
_____ _____
_____ _____

Current Health Condition

Present Complaint - Reason For Your Visit Today

Major _____

Pain or Problem started on _____

Pains are: ❒ **Sharp** ❒ **Dull** ❒ **Constant** ❒ **Intermittent**

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse? _____

Other doctors seen for this condition? _____

Any home remedies? _____

Accident Information

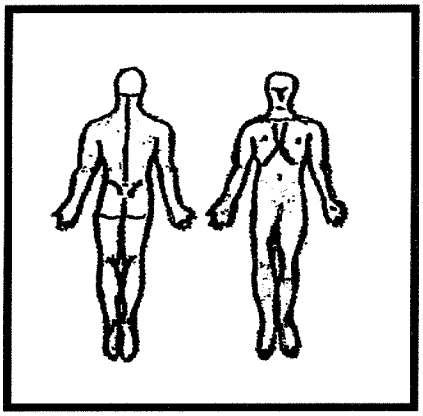
Is condition due to an accident? Y N Date _____

Type of accident ❒ Auto ❒ Work ❒ Home ❒ Other

To whom have you made a report of your accident? ❒ Auto Insurance ❒ Employer ❒ Worker Comp ❒Other

Attorney Name (if applicable) _____

Mark an X on affected areas



Other symptoms:

- ❒ Headaches
- ❒ Dizziness
- ❒ Light Bothers Eyes
- ❒ Loss of Memory
- ❒ Loss of Taste
- ❒ Loss of Smell
- ❒ Loss of Balance
- ❒ Buzzing in Ear
- ❒ Ringing in Ear
- ❒ Face Flushed
- ❒ Fever
- ❒ Fainting
- ❒ Cold Sweats
- ❒ Depression
- ❒ Nervousness
- ❒ Fatigue
- ❒ Tension
- ❒ Neck Pain
- ❒ Stiff Neck
- ❒ Chest Pains
- ❒ Shortness of Breath
- ❒ Back Pain
- ❒ Sleeping Problem
- ❒ Stomach Upset
- ❒ Constipation
- ❒ Diarrhea
- ❒ Irritability
- ❒ Cold Hands
- ❒ Cold Feet
- ❒ Numbness in Fingers
- ❒ Numbness in Toes
- ❒ Pins & Needles in Arms
- ❒ Pins & Needles in Legs
- ❒ Other _____

Family Health History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	❒	❒	❒	❒	❒
Mother's Side	❒	❒	❒	❒	❒

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to **(Please check all that apply)**

- ❒ Feel better quickly
- ❒ Have a healthier spine
- ❒ Have a healthier body by keeping my nerve system healthy
- ❒ Live a healthier lifestyle

_____ Signature

_____ Date