



NEW PATIENT HEALTH HISTORY

Name: _____ Date: _____ Age: _____
 Birth date: (M) _____ (D) _____ (Y) _____ Marital Status: Single Married/Common Law Divorced Widowed
 Spouse/Significant Other Name: _____ # of children: _____ and their ages: _____
 Address: _____ City: _____
 Postal code: _____ Email Address: _____
 Home Phone: _____ Cell Phone: _____
 Workplace: _____ Occupation: _____
 How did you learn about our clinic? (Patient? Promotion? Print?) _____
 Family Doctor's Name: _____ Phone Number: _____

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 poor health. Following your exam, Dr. John will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Childhood History

- Born by Forceps
- Born by Cesarean
- Born Breech
- Stomach sleeper as a child
- On Antibiotics as a child
- Used puffers as a child

Childhood Sports: _____

Childhood Surgeries: _____

After Childhood to Present

- Smoke
- Drink Alcohol
- Eat unhealthy foods
- Little to no exercise
- Stress (Work, Family, Financial etc)
- Computer (work or home)
- Sit at work mostly
- Stand at work mostly
- Stomach sleeper
- Issues with your weight

Adult Sports/Recreation: _____

Date of last sports trauma, and related injuries: _____

Date of last work accident, and related injuries: _____

Date of last slip or fall, and related injuries: _____

Date of last car accident, and related injuries: _____

Adult surgeries: _____

Medications you are currently taking: _____

Have you seen a chiropractor in the past? Y N If yes, when was your last adjustment? _____

How often did you see your chiropractor? _____

What is your present health concern today? _____

How long have you had this condition? _____

What aggravates this condition? _____ What relieves it? _____

What other doctors have treated you for this condition? _____

How is this condition interfering with your life? _____

What are some other health concerns you have? _____

Please provide details about the pain you are experiencing in any of the following areas, and if it is an ache and/or a sharp pain:

Neck Pain:

- Constant Comes and Goes Right side Left Side Both Sides Ache Sharp Pain

Upper Back Pain (between the shoulder blades)

- Constant Comes and Goes Right side Left Side Both Sides Ache Sharp Pain

Mid Back Pain:

- Constant Comes and Goes Right side Left Side Both Sides Ache Sharp Pain

Low Back Pain:

- Constant Comes and Goes Right side Left Side Both Sides Ache Sharp Pain

Does the low back pain ever radiate down into the : R Leg L Leg Groin Buttocks

Shoulder Arm Hand: Pain Numbness/Tingling

Details: _____

Hip Leg : Pain Numbness/Tingling

Details: _____

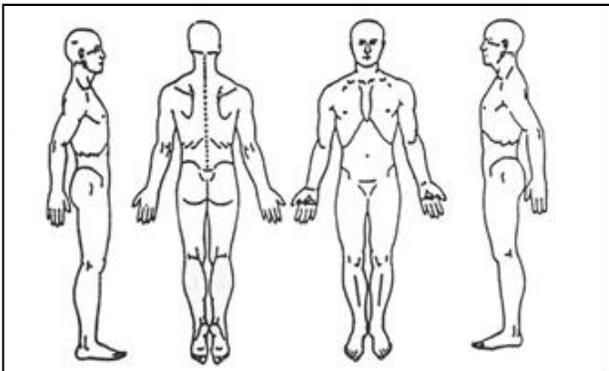
Knee Foot: Pain Numbness/Tingling

Details: _____

Symptoms may indicate a long standing spinal condition. Check off symptoms you have now, or have had in the past.

Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Concentration	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds, Flu
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Pain
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Below, please mark an **X** on the areas where you feel pain.



Chiropractor/Exam CA Notes:
