

Branchville Family Chiropractic

Online Health History Form

(to print out and bring to your first visit to save you time)

The practice of Chiropractic is based on the location and correction/adjustment of spinal misalignments, called VERTEBRAL SUBLUXATIONS. Subluxations are caused by any stress which your body can not adapt to or recover from. These stresses may be PHYSICAL, CHEMICAL, or MENTAL/EMOTIONAL in nature. The following questions will relate to possible causes of Vertebral Subluxation in your spine. Please answer these questions as completely as possible. If you have any questions about the importance of any section, ask about that part during your personal consultation with the doctor. Welcome and we hope your Chiropractic Care experience with us is beneficial to you and your family.

Personal & Health History

Name: _____ Age: ____ Birth Date: _____ Sex: M F
Address: _____ City: _____ State/Zip: _____
Home Phone: ____ - _____ E-Mail: _____ SS#: _____
Marital: S M D W Spouse' Name: _____ Children & ages: _____
Employer: _____ Occupation: _____
Work Phone: ____ - _____

Activities / sports / hobbies: _____
Family's activities / interests: _____

Who will be responsible for your bill? Self ____ Spouse ____ Parent ____ Other _____
I intend to pay for my care by: Cash ____ Check ____ Credit Card: VISA MC AMEX DISC
Will there be an insurance claim involved? Yes / No
Type Policy: Personal ____ Group Health ____ Auto ____ Medicare ____ Personal Injury ____
Other _____
Insurer: _____ Name of Insured: _____
Insured D.O.B. _____ Insured SS#: _____
Group #: _____ Policy #: _____ Insured's Employer _____

I was referred to this office by: _____
I have heard about your office from: (please circle all that apply) Newspaper Mailing
Telephone Friend Location Other _____

Health History:

My reason for today's visit is _____

Physical Stresses:

My birth was: Normal ____ Difficult ____ Drug Induced ____ C Section ____
Forceps/Suction ____ Prolonged ____
List any Falls, Jolts, or Impacts: _____

Sports Injuries: _____

Broken Bones: _____
Accidents: (Auto, Motorcycle, Bike, Bus, Airplane, etc. Please provide dates and severity of injuries.) _____

Hospitalizations/surgeries: (dates and reason) _____

Do you still have all of your body parts: (tonsils, appendix, etc.) Yes / No explain _____

List Prolonged or frequent childhood illnesses: (Ear Infections, Asthma, Allergies, etc.) _____

Chemical Stresses:

Vaccinations: No / Yes (which ones?) _____

Are you taking any medication now? No / Yes (what & why?) _____

Allergies: No / Yes (to) _____

I: Smoke ___ packs/day Drink alcohol ___ Diet regularly ___ Caffeine (coffee/tea/soda) ___

NutraSweet ___ Work with toxic chemicals ___ Commute in traffic (1/2 hour or more) ___

Mental Stresses:

Known psychological disorders: _____

I would rate my level of mental stress:

Very High ___ High ___ Moderate ___ Low ___ Very Low ___

On a scale of 1 (low) to 5 (high) how would you rate your level of stress (lifetime) from:

Childhood 1 2 3 4 5 Relationships 1 2 3 4 5 Work 1 2 3 4 5 Family

1 2 3 4 5

Lifestyle 1 2 3 4 5 Being Sick 1 2 3 4 5

Previous Health Care:

Family Physician: Dr. _____ Phone # (if known) ___ - _____

Last visit: _____

Previous Chiropractic Care: Dr. _____ Phone # (if known) ___ - _____

Last visit: _____ Reason for care _____

How long under care _____

Would you object to us conferring with your previous or other physicians about your care if necessary? No Yes

Expectations for your care here:

Relief Only ___ Correction of Problem ___

Prevention of Health Problems ___

Family Wellness Care ___

Other _____

All of the statements made on this form are accurate and complete to the best of my recollection.

Patient/Parent/Guardian: _____ **Date:** _____