

Sierra Chiropractic
Confidential Personal Health History

Dear New Patient,

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients. Please let us know if there is any way we can make you and your family feel more comfortable. To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Date: _____
Name (please print): _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Cell/Voice mail: _____ E-mail: _____
Birth Date: _____ Age: _____ SS#: _____ - _____ - _____
Employer: _____ Occupation: _____
Marital Status: S M D W # of Children: _____
Spouse's name: _____
Children's names/ages: _____
Referred By: _____
Reason for Chiropractic Care: _____

ACCIDENTS

What accidents have you had? (car, bicycle, motorcycle, sports, falls, etc.) Include dates:

SURGERY/MEDICAL CONDITIONS

What major surgery, broken bones, or medical conditions do you have, or have you had, in the past? Include dates:

What other surgical procedures have you undergone? (such as: tonsillectomy, appendectomy, wart or cyst removal, dental extraction, cosmetic procedures) Include dates:

MEDICATIONS

Are you currently taking any prescription medications? YES NO
Please list all medications:

In the past, have you taken any of the following?

- Antibiotics Steroids/Cortisone/Prednisone Birth control pills

Name: _____

(MEDICATIONS cont'd)

Have you been vaccinated? Yes No

Are you currently taking any over-the-counter medications? Please list: _____

YOUR BIRTH HISTORY

Type of birth(check all that apply): Vaginal Cesarean Vacuum extraction

Forceps Unknown

Were there any complications during your mother's pregnancy? Please describe: _____

Were there any complications during or after your birth?

CURRENT HEALTH

Height: _____ Weight: _____ lbs.

How would you rate your current health?

Poor Fair Average Good Excellent

How would you describe your family's health?

Poor Fair Average Good Excellent

Please rate the level of stress in your life.

Mild Moderate Extreme

Are you currently on a special diet?

Yes No

Type of diet: _____

What are the 5 **healthiest habits** you currently choose in your life?

1. _____
2. _____
3. _____
4. _____
5. _____

What are the 5 **least healthy habits** you currently choose in your life?

1. _____
2. _____
3. _____
4. _____
5. _____

Please rate the **importance** of health in your life.

	1	2	3	4	5	6	7	8	9	10
Not										Most
Important										Important

Please indicate **any areas of pain/discomfort** and **describe** how it feels. (Such as: Sharp/Stabbing, Dull, Achy, Pins & Needles, Numbness, Hot/Burning, Cold)

FINANCIAL INFORMATION

Who is responsible for this account? _____

Name: _____

QUESTIONNAIRE

Directions: If you **CAN POSSIBLY** answer YES, circle YES. If you **MUST** answer NO, circle NO. Please **answer all** questions. If you are not sure, do your best.

- | | | |
|---|-----|----|
| Has your eyesight ever blacked out completely? | YES | NO |
| Are you hard of hearing? | YES | NO |
| Do you have allergies? | YES | NO |
| Have you ever coughed up blood? | YES | NO |
| Have you suffered frequent cramps in your legs? | YES | NO |
| Has a doctor ever said you have heart problems? | YES | NO |
| Do you often eat sweets between meals? | YES | NO |
| Has a doctor ever said you have ulcers? | YES | NO |
| Does pressure or pain in your head often make life miserable? | YES | NO |
| Have you fainted more than twice in your life? | YES | NO |
| Do you have numbness or tingling in any part of your body? | YES | NO |
| Have you ever been knocked unconscious? | YES | NO |
| Are you or were you a bed wetter? To what age? | YES | NO |
| Have you ever passed blood while urinating? | YES | NO |
| Have you ever been treated for a tumor or cancer? | YES | NO |
| Do you often have small accidents or injuries? | YES | NO |
| Have you ever had a serious injury? | YES | NO |
| Are you frequently ill? | YES | NO |
| Do you consider yourself a nervous person? | YES | NO |
| Has a doctor ever said your blood pressure was too high? | YES | NO |
| Have you been told you have osteoporosis? | YES | NO |
| Have you been told you have rheumatoid arthritis? | YES | NO |
| Do you know that the innate intelligence of the body is the power that heals the body, like with a cut finger? | YES | NO |
| Do you know that each cell must receive its impulse from the brain, and that interference will cause malfunction? | YES | NO |
| Do you know that chiropractors remove subluxations that interfere with the communication between the brain and the cells? | YES | NO |

Name: _____

1. Have you ever been to a chiropractor before? If yes, who, when, and why?

2. What did your previous chiropractor do?

3. What are your expectations for care now?



Dr.'s Notes:
