

Enhance Your Life Chiropractic Personal History Questionnaire

Please wear loose fitting clothes. Avoid clothes with bulky seams, such as jeans. Thanks

Name: _____ Today's Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (H) _____ (W/Cell) _____ E-Mail: _____

Birth date _____ Monthly newsletter with calendar preference: e-mail mail

How did you hear about our office? _____

Please complete this general health history survey as it will provide us with important information to better understand your history, your present and longer term needs, and any compromise to your wellness or health related quality of life that you may now be experiencing.

Objectives of this questionnaire:

- ◆ To help us understand the factors in your life which may have impacted your nervous system and spine.
- ◆ To help us understand your objective and concerns in selecting our professional service.
- ◆ To gain enough information about you, the person, so that we can better conduct a spinal evaluation called an analysis.
- ◆ To begin a process of helping you to understand that where you are now is in relationship to cumulative factors which have influenced you up to now. (Previous circumstances and events determine who you are today.)

These questions will help us better understand the uniqueness of you.

Health and Wellness History

Have you ever had your spine professionally adjusted? YES NO

If Yes, by whom, and when? _____

For how long were you receiving chiropractic adjustments? _____

How often did you go? _____

If you stopped, why did you stop care? _____

What technique or methods did the chiropractor use? _____

Were you pleased with their service? YES NO

Does your immediate family receive chiropractic care? YES NO

Have you had experience with the following treatments or healing modalities? If so, please describe when you went, for how long you went and what the results were:

- Physiotherapy/Occupational Therapy: _____
- Bodywork/Massage: _____
- Osteopathy/Cranial Work: _____
- Homeopathy/Herbalist: _____
- Oriental Medicine/Acupuncture: _____
- Nutritional Counseling: _____
- Chelation Therapy: _____

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- Meditation/Prayer: _____
- Psychotherapy: _____
- Yoga/TaiChi/Movement/Dance: _____
- Rebirthing/Breathwork: _____
- Other: _____

Do you have any current health concerns?

What do you hope to receive from chiropractic care in this office? _____

PHYSICAL STRESS HISTORY

Birth Stress- If you have information about your birth history:

Was your mother outwardly ill prior to your birth? YES NO

Did she have a difficult pregnancy with you? YES NO

Was your birth traumatic? YES NO

Please check those that apply to your birth:

C-Section

Cord around neck

Drug Induced

Prolonged

Breech

Natural

Suction

Other _____

Please describe any other physical or mechanical stress to you or your mother as labor progressed, or as a newborn.

General Physical Traumas

Have you ever injured your spine (neck, head, back, hips, or tailbone)?

a). Date of **most significant** injury: _____

b). What happened? _____

c). Date of **most recent** injury: _____

d). What happened? _____

Were you ever knocked unconscious? YES NO

Comments: _____.

Have you ever used crutches, a cane, or a walker? YES NO

Have you ever broken any bones or significantly sprained part of your body? YES NO

Comments: _____.

Have you had extensive dental or orthodontic work performed? YES NO

Comments: _____.

During the day I...

Sit

Desk work

Stand

Mechanical work

Walk

Heavy lifting

Drive

Other information _____

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Sports or Leisure

Do you exercise? YES NO If yes, how often? _____

Are you active in any particular sports? _____

Have you ever been injured in any of these activities? _____

Do you read for prolonged periods? YES NO

I wear: glasses bifocals contact lenses

Accidents or other traumas

Have you, even as a passenger, even if you do not think you were hurt, been involved in a vehicular collision or near collision?

Year	Description	Severity (Mild, Moderate, Extreme)

Bus, bicycle, train, motorcycle, airplane or other motor vehicles? _____

Medical Treatment

Have you ever been hospitalized? YES NO

If yes, what was done to you? _____

Have you had surgery? _____

Do you still have all of you body parts? _____

Have you had?

- Spinal tap
- Spinal injection
- Spinal brace
- Traction
- Heel lifts
- Extensive diagnostic x-rays
- Corrective shoes
- Chemotherapy/ Transfusion
- Body part in a cast or immobilized

Are you now taking any over the counter or prescription drugs? YES NO

Please list drugs, when prescribed and reason for taking them? _____

Please list any herbs, nutritional supplements or natural remedies you take regularly.

Have you ever in the past taken any medication or supplement for an extended period of time (for example: oral birth control, acne medication, used an inhaler as a child, etc.)?

YES NO

If yes, please list _____

Do you or did you work with any chemical fume, dust, powder or smoke for prolonged periods?

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Please check the dietary selections that are appropriate for you:

- | | | |
|--|---|--|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Soda | <input type="checkbox"/> Organic foods |
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Diet foods | <input type="checkbox"/> Fasting |
| <input type="checkbox"/> Artificial Sweeteners | <input type="checkbox"/> Refined Sugars | <input type="checkbox"/> Raw foods |

Stress Survey - Please grade the following stresses in order of increasing intensity.

- | | |
|---------------------------------|-----------------------------------|
| 1. means no awareness of stress | 3. moderately stressful situation |
| 2. slightly stressful situation | 4. extremely stressful situation |

Overall Physical Stress/Trauma: 1 2 3 4

Please circle the stresses you have been most affected by and include comments:

This can include: falls, accidents, injuries, repeated postural stress impacts, difficult birth, traction, and physical abuse.

Comments: _____

Overall Emotional/Mental Stress: 1 2 3 4

This can include: loss of loved ones, rapid change in life situation, mental, emotional or sexual abuse, legal concerns, financial concerns, move of home/school, separation/divorce, etc., stress in relationships, stress of being ill, etc.

Comments: _____

Overall Chemical Stress: 1 2 3 4

This can include: drugs, smoke, fumes, food additives, etc.

Comments: _____

About your uniqueness

1. Do you have an exercise, meditation, prayer, nutritional or dietary program? YES NO

Please describe: _____

2. When stressed, how do you “center yourself” or “re-group”? _____

3. How do you grade your physical health: Poor Fair Good Excellent

Is it? Getting better Getting worse

4. How do you grade your emotional/mental health: Poor Fair Good Excellent

Is it? Getting better Getting worse

If you consider yourself ill, why do you feel you are ill? _____

If you consider yourself well, why do you feel you are well? _____

Is there anything else you wish to share which will help us to better understand you, and why you have chosen to receive care in this office?

