

## Enhance Your Life Chiropractic - Personal History Questionnaire

Please wear loose fitting clothes for your visit. Avoid clothes with bulky seams, such as jeans.

**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.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W/Cell) \_\_\_\_\_

E-Mail: \_\_\_\_\_ Birth date \_\_\_\_\_

We offer a newsletter with articles, and office hours, would you like  e-mail  mail delivery?

How did you hear about our office?

\_\_\_\_\_

Do you have any current health concerns?

\_\_\_\_\_

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

\_\_\_\_\_

### **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: \_\_\_\_\_
- Meditation/Prayer: \_\_\_\_\_
- Psychotherapy: \_\_\_\_\_
- Yoga/TaiChi/Movement/Dance: \_\_\_\_\_
- Rebirthing/Breathwork: \_\_\_\_\_
- Other: \_\_\_\_\_

**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:

- |                                       |   |
|---------------------------------------|---|
| <input type="checkbox"/> C-Section    | <input type="checkbox"/> Cord around neck |
| <input type="checkbox"/> Drug Induced | <input type="checkbox"/> Prolonged        |
| <input type="checkbox"/> Breech       | <input type="checkbox"/> Natural          |
| <input type="checkbox"/> Suction      | <input type="checkbox"/> Other _____      |

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

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**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...**

- |                                |  |  |
|--------------------------------|--|--|
| <input type="checkbox"/> Sit   | <input type="checkbox"/> Drive           | <input type="checkbox"/> Heavy lifting     |
| <input type="checkbox"/> Stand | <input type="checkbox"/> Desk work       | <input type="checkbox"/> Other information |
| <input type="checkbox"/> Walk  | <input type="checkbox"/> Mechanical work | _____                                      |

**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? \_\_\_\_\_

**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?

\_\_\_\_\_

Thank You.

On your first visit we will review your history, examine your spine, evaluate your posture, and you will receive your first spinal entrainment. If you have a moment before your first visit, please check out the videos on our website: [www.eylc.com](http://www.eylc.com). We look forward to meeting you!