

JUDSON FAMILY CHIROPRACTIC
PERSONAL HEALTH HISTORY
WELCOME TO OUR FAMILY!

Date _____
Name _____ Patient # _____
Address _____ City/State/Zip _____
Date of Birth _____ Social Security Number _____
Home Phone # _____ Cell Phone # _____ Work Phone # _____
Marital Status S M D W E-mail address _____
Spouse's Name & Age _____ Spouse's Occupation _____
Children's Names & Ages _____

Name of Employer _____ Occupation _____
Hobbies _____
Who referred You _____

Name of Previous Chiropractors _____ When was your last visit? _____
For how long were you receiving Chiropractic adjustments? _____

Reason for coming in _____

What accidents have you had (ex. Bicycle, car, motorcycle, sports, slips/falls) at work or at home (include dates) _____

Were you ever knocked unconscious? _____
What fractures or broken bones have you had? (include dates) _____

SURGERY:

What major surgery have you had? (include dates) _____

What minor surgery have you had? (tonsillectomy, appendectomy, wart/cyst removal, dental extraction) _____

MEDICATION:

Present Prescription Drugs	Past Prescription Drugs	Over-The-Counter Drugs (aspirin, cold tablets, cough syrup)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

THERAPY:

Are you presently under any therapeutic care? (what type) _____

What therapeutic care have you been under in the past (radio, chemo, physio, electro, etc., include dates) _____

YOUR BIRTH RECORD:

Type of birth (Vaginal, Cesarean, etc.) _____
Any complications during your mother's pregnancy or during your birth? _____
Any complications after your birth? _____

CURRENT HEALTH:

How would you describe your current health? _____
How would you describe your family's health? _____
Describe your: Vision _____ Hearing _____ Coordination _____
Do you use any of the following: Tobacco Alcohol Coffee/tea regular cola diet cola milk
Level of stress in your life: mild moderate extreme 1 2 3 4 5 6 7 8 9 10
Do you purchase any of the following: **Bottled Drinking Water:** () No () Yes
Vitamins: () No () Yes **Health Food Products** (organic products, etc.) () No () Yes

FINANCIAL INFORMATION:

Who is responsible for this account? _____
What method of payment will you be using? Insurance Cash Check MC/Visa/Discover/AmEx Other
Name of Insurance Company _____ Policy # _____
Insured's Date of Birth _____
Do you have secondary insurance? () Yes () No
Name of Insurance Company _____ Policy # _____

Please check any of the following that give you difficulty or you have had recently

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Headaches 784.0 | <input type="checkbox"/> Fainting 780.2 | <input type="checkbox"/> Menstrual Cramp/Pain 625 | <input type="checkbox"/> Kidney trouble 593.9 |
| <input type="checkbox"/> Shooting head pains 784.0 | <input type="checkbox"/> Loss of Balance 781.2 | <input type="checkbox"/> Heart attack 410.9 | <input type="checkbox"/> Loss of taste 781.1 |
| <input type="checkbox"/> Sinus Trouble 473.9 | <input type="checkbox"/> Ringing iin the ears 388.3 | <input type="checkbox"/> Low blood pressure 458.9 | <input type="checkbox"/> Inflammation of throat 462 |
| <input type="checkbox"/> Neck Pain 723.1 | <input type="checkbox"/> Blurred vision 368.0 | <input type="checkbox"/> High blood pressure 401.9 | <input type="checkbox"/> Diabetes 250.0 |
| <input type="checkbox"/> Allergies 995.3 | <input type="checkbox"/> Lights bother eyes 368.13 | <input type="checkbox"/> Anemia 285.9 | <input type="checkbox"/> Thyroid trouble 246.9 |
| <input type="checkbox"/> Muscle spasms in neck 781 | <input type="checkbox"/> Stomach trouble 789 | <input type="checkbox"/> Menstrual Irregularity 626 | <input type="checkbox"/> Painful joints 719.4 |
| <input type="checkbox"/> Grinding in Neck 719.4 | <input type="checkbox"/> Nerves/Nervousness 799.2 | <input type="checkbox"/> Sleeping Problems 780.5 | <input type="checkbox"/> Swollen joints 719.0 |
| <input type="checkbox"/> Shoulder/arm tight 728.85 | <input type="checkbox"/> Inner Tension 799.2 | <input type="checkbox"/> Pain in legs/feet 719.4 | <input type="checkbox"/> Pins & needles in leg 782 |
| <input type="checkbox"/> Shoulder/arm pain 719.4 | <input type="checkbox"/> Irritability 799.2 | <input type="checkbox"/> Hip Pain 719.45 | <input type="checkbox"/> Swollen ankles 782.3 |
| <input type="checkbox"/> Pins & Needles in arms 782 | <input type="checkbox"/> Indigestion 536.8 | <input type="checkbox"/> Gall bladder trouble 579 | <input type="checkbox"/> Cold feet 782 |
| <input type="checkbox"/> Numbness in arms/hands 782 | <input type="checkbox"/> Low back pain 724.2 | <input type="checkbox"/> Loss of Smell 781.1 | <input type="checkbox"/> Facial twitch 781 |
| <input type="checkbox"/> Mid back pain 724.1 | <input type="checkbox"/> Cold hands 782 | <input type="checkbox"/> Intestinal Gas 787.3 | <input type="checkbox"/> Loss of Memory |
| <input type="checkbox"/> Fatigue 780.7 | <input type="checkbox"/> Numbness in legs/feet 782 | <input type="checkbox"/> Hay Fever 477.8 | <input type="checkbox"/> Facial pain 784.0 |
| <input type="checkbox"/> Depression 311.0 | <input type="checkbox"/> Tonsillitis 784 | <input type="checkbox"/> Hernia 550.1 | <input type="checkbox"/> Jaw pain (TMJ) 525.9 |
| <input type="checkbox"/> Dizziness 780.4 | <input type="checkbox"/> Prostate Trouble 601.4 | <input type="checkbox"/> Stroke 436.0 | <input type="checkbox"/> Ulcers 534. |
| <input type="checkbox"/> Spinal curvature 737.43 | <input type="checkbox"/> Bed wetting 788.3 | <input type="checkbox"/> Arthristis 716.96 | |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Cancer | <input type="checkbox"/> Asthma 493.9 | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Shortness of breath 786.0 | <input type="checkbox"/> Constipation 564.0 | |

Dr.'s Notes: _____

