PERSONAL HEALTH HISTORY FORM

Today's Date_____

Name_____ Age _____ Date of Birth _____

Parent's names (if you are under 18)_____

Home Address_____City _____ State_____ Zip _____

Home phone (____) _____ Business Phone (____) _____

Cell Phone (____) _____ E-mail address _____

Occupation_____ Employer_____

SS# _____ Emergency contact _____

Marital Status S M D W Name of Spouse _____

Names and Ages of Children_____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Chrysalis Chiropractic can address for you?

_____

_____

Is this concern affecting your quality of life? (Please circle only those applicable to you)

Work:	Y	N	Recreation:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports	Y	N	Eating:	Y	N	Other:_____		

Pain or Problem started on_____Pains are:❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent

Rate your pain on a scale of 1 to 10 – (1 is no pain 10 is the worse pain ever): _____

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is condition worse during certain times of the day? _____

Is this condition getting progressively worse? _____

Other Doctors seen for this condition _____

Any home remedies? _____

Have you had this pain before? _____

If, yes what helped?_____

Other symptoms:

❒ Headaches	❒ Face Flushed	❒ Light Bothers Eyes	❒ Feet Cold
❒ Neck Pain	❒ Neck Stiff	❒ Loss of Memory	❒ Hands Cold
❒ Sleeping Problems	❒ Pins & Needles in Legs	❒ Ears Ring	❒ Stomach Upset
❒ Back Pain	❒ Pins & Needles in Arms	❒ Fever	❒ Constipation
❒ Nervousness	❒ Numbness in Fingers	❒ Fainting	❒ Loss of Balance
❒ Tension	❒ Numbness in Toes	❒ Cold Sweats	❒ Buzzing in ears
❒ Irritability	❒ Shortness of Breath	❒ Loss of Smell	
❒ Chest Pains	❒ Fatigue	❒ Loss of Taste	
❒ Dizziness	❒ Depression	❒ Diarrhea	

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? Y N With whom_____
How long under care? _____Date of last visit: _____Why did you stop? _____
Was there a particular health concern for which you consulted the chiropractor?

_____

Have you consulted or do you regularly consult any of the following care providers? (check all that apply)

❑ Medical Physician ❑ Naturopath ❑ Acupuncturist ❑ Homeopath
❑ Massage Therapist ❑ Psychotherapist ❑ Energy Healer ❑ Dentist

Reason why: _____

_____

FOR WOMAN: Are you pregnant? Y N If pregnant, what is due date? _____

Name of OBGYN or Midwife _____

Where will you be birthing your baby? ❑ Hospital ❑ Home ❑ Birthing Center ❑ Other_____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The human body is designed to be healthy. The primary system in the body which coordinates health is the NERVE SYSTEM. The vertebrae, (bones of the spine) surround and protect the delicate NERVE SYSTEM. Physical, emotional and chemical stresses, common to our contemporary lifestyles, can result in misalignment to the spinal column as well as damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic Exam/evaluation determines if your spine shows signs of the Vertebral Subluxation process.

Please review and indicate your history of "stresses" (below) so that we can assess their relationship to your present health status and examination findings. We will discuss this during the consultation.

HISTORY OF PHYSICAL STRESSES (Birth to Present)

The *birth process* can traumatize **a baby's spine and cause *damage to the nerve system*. Please indicate to the best of your recollection where and how you were birthed.** (check all that apply) **If you do not know, please skip to next question.**

❑ Home ❑ Natural ❑ Hospital ❑ Caesarian section ❑ Forceps
❑ Breech ❑ Cord around neck ❑ Prolonged labor ❑ Drug induced labor ❑ Suction

The information below will help us to see the types of PHYSICAL stresses that you have been subjected to and how they may relate to your present health status.

Have you had any accidents related to any of the following? (check all that apply)

❑ Automobile ❑ Motorcycle ❑ Bicycle ❑ Sports ❑ Playground ❑ Abuse

If yes, please explain how and dates:

_____

_____

Have you ever injured your spine (head, neck, rib/chest area, back, pelvis or hips)? Y N

If yes, please explain how and dates:

_____

_____

Have you ever broken any bones or sprained any part of your body? Y N

If yes, please explain how and dates:

_____

_____

Have you ever been hospitalized? Y N If yes, please explain how and dates:

HISTORY OF CHEMICAL STRESSES

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed on the skin that is toxic to the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will give us insight into any exposures you may have had.

Were you vaccinated? Y N If yes, did you have a reaction? Y N If yes, please explain: _____

Do you consume any of the following presently?

❑ Coffee/caffeine ❑ Alcohol ❑ Tobacco ❑ Over the counter drugs ❑ Prescribed drugs

Please list all medications (prescribed and over the counter):_____

HISTORY OF EMOTIONAL STRESSES

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work or School	Y	N	Divorce/separation	Y	N	Financial	Y	N
Lifestyle change	Y	N	Parents divorce	Y	N	Illness	Y	N

QUALITY OF LIFE

How do you grade your physical health?	❑ Good	❑ Fair	❑ Poor
How do you grade your emotional/mental health?	❑ Good	❑ Fair	❑ Poor
How do you rate your overall "quality of life"?	❑ Good	❑ Fair	❑ Poor

EXPECTATIONS

As a result of my Chiropractic Care, I would like to: (Check all that apply)

❒ Feel better quickly ❑ Have a healthier nerve system
❒ Have a healthier spine ❑ Have optimum health on all levels

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Dr. David Capps, DC and/or Dr. Lola Capps, DC permission to render care to me today. This initial visit includes a health history/consultation, chiropractic exam/evaluation, and any initial care that is determined to be clinically necessary and mutually agreed upon.

*Signature*_____ *Today's Date*_____

*Signature of Parent (for minor):*_____ *Today's Date*_____