

Welcome to First Chiropractic Family Wellness Center

Dr. Brian Miller / Dr. Bryan Haas

GENERAL INFORMATION

Full Name _____ Age ____ DOB ____/____/____

Home Phone (____) _____ Cell (____) _____ E-mail _____

Home Address _____ City _____ State ____ Zip _____

Marital Status S M D W Name of Spouse _____

Names and Ages of Children _____

Occupation _____ Business Phone (____) _____

Whom may we thank for referring you to our office _____

Have you ever received Chiropractic care? Yes No With whom? _____

How often did you go? _____ Date of last visit: ____/____/____

Reason for ending care _____

Have you had spinal x-rays? Yes No What did they show? _____

What hobbies or activities do you enjoy? _____

Name of current medical doctor: _____ Phone # (____) _____

Date of last medical consultation and reason: ____/____/____ - _____

For women: Are you pregnant? Yes No

YOUR HEALTH HISTORY

Throughout life, stress and traumatic events can damage your spine and nerve system. This stress may be **PHYSICAL, CHEMICAL** and/or **EMOTIONAL**. The information below will help us better understand the stress that you have been subjected to. We use this information along with your examination findings in order to design a custom wellness program for health and longevity.

HISTORY OF PHYSICAL STRESS (Birth to Present)

Research indicates that the birth process causes trauma to a baby's delicate spine and nerve system. Please circle (to the best of your recollection). Was your birth:

Drug induced C section Breech Natural Home Birth Midwife
Vacuum extraction Prolonged Umbilical cord around neck Forceps Hospital

GENERAL PHYSICAL TRAUMA:

Most traumas occur in the early years (between birth and early twenty's). During that time your spine and nerve system is growing and most vulnerable to injury.

Have you had accidents related to the following: (Circle all that apply and give dates.)

Automobile Motorcycle Bicycle Sports Horseback Recreation Work

Other _____

If yes, please explain: _____

Have you broken any bones or sprained any part of your body? Yes No

If yes, please explain: _____

Have you ever had surgery or have you been hospitalized? Yes No

If yes, please explain: _____

How many times a week do you exercise? 1 2 3 4 5 6 7 (Please circle)

HISTORY OF CHEMICAL STRESS

Chemical stress occurs during life due toxic substances that are breathed, injected, taken orally, or placed on the skin and absorbed into the body. The following will give us insight into any exposures you may have had.

Do you currently take? Prescription drugs _____

Over the counter _____

Have you previously been exposed to or are you currently exposed to?

Cortisone Flu shots Chemicals Fumes Dust Smoke Cigarettes

How often do you consume? N= Never/Rarely D=Daily W=Weekly M=Monthly

Alcohol___Coffee___Tobacco___Diet Soda___Fast Food___Junk Food___

What is your blood type? ___What vitamins do you take?_____

How much water do you drink per day? _____

HISTORY Of EMOTIONAL STRESS

Emotional stress creates tension in your spine and nerve system. Although it is common to be under stress, it can have a detrimental affect on your overall health.

Please circle the emotional stresses you have encountered.

Childhood trauma	Yes No	Relationships	Yes No	Illness	Yes No
Loss of Loved One	Yes No	Family	Yes No	School	Yes No
Divorce/Separation	Yes No	Financial	Yes No	Abuse	Yes No
Lifestyle change	Yes No	Work	Yes No	Other	Yes No

QUALITY OF LIFE

How do you grade your physical health? Excellent Good Fair Poor

How do you grade your emotional health? Excellent Good Fair Poor

How do you grade your nutritional health? Excellent Good Fair Poor

How do you rate your overall "quality of life"? Excellent Good Fair Poor

REASON FOR SEEKING CHIROPRACTIC CARE

What is the reason for your visit today? _____

Please circle the symptoms you have now or have had within the past 6 months.

Back pain	Numbness	Fatigue	Hair loss
Neck pain	Cold hands/feet	Ears ring	Depression
Leg/knee/foot pain	Asthma	Chest pain	Nail fungus
Shoulder pain	Allergies	Food cravings	Catch colds easy
Elbow/wrist pain	Indigestion	Skin problems	Constipation
Headaches	Hot flashes	Earaches	Diarrhea
Dizziness	Hormone problems	Sinus problems	Arthritis
Insomnia	High blood pressure	Feeling old	Other _____

Is your current health affecting any of the activities below? (Please circle)

Work: Yes No	Recreation: Yes No	Sleep: Yes No
Social life: Yes No	Walking: Yes No	Sitting: Yes No
Exercise: Yes No	Eating: Yes No	Family: Yes No
School: Yes No	Marriage: Yes No	Finances: Yes No

If your current health condition was allowed to continue for the next 5 years, how do you think it would affect you? _____

What one thing would like to be able to do that your health is preventing from doing?

PLEASE CHECK YOUR CURRENT HEALTH GOALS

- I am only concerned with my immediate problem and want a temporary quick fix.
- I am concerned with my immediate problem and preventing its return.
- I want to achieve optimum health and well-being on every level!

Terms of Acceptance

We are a Wellness Center specializing in the detection, correction and prevention of vertebral subluxations (spine and nerve system problems). We do not treat or diagnose medical conditions nor dispense drugs. Today our job is to evaluate the health of your spine and nerve system. If we accept your case, you will be scheduled for a special visit with the doctor to discuss the results of your exam. Recommendations will then be made outlining the action steps needed to improve your health. Our methods include spinal adjustments, innate nutrition, rehabilitative exercises, orthotics, and stress reduction.

By signing below, I understand and agree to these terms

Signature _____

Date ____/____/____

Signature of Parent (for minor): _____

Date ____/____/____