

# WEST LOOP CHIROPRACTIC HEALTH HISTORY FORM

Please fill out this form as completely and accurately as possible.

## PERSONAL DATA

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 \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Marital Status  S  M  D  W  L/W Spouse/Partner \_\_\_\_\_

Names and Ages of Children \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## REASON FOR SEEKING CHIROPRACTIC CARE

What health issues bring you into our office today? \_\_\_\_\_

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

## HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care?  Y  N Name of D.C. \_\_\_\_\_

How long under care?  \_\_\_\_\_ days  \_\_\_\_\_ weeks  \_\_\_\_\_ months  years \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Why did you stop? \_\_\_\_\_

Have you consulted or do you regularly consult any of the following 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 Date of last menstrual period: \_\_\_\_\_

If x-rays are recommended, your signature is required (below) to indicate that you are **not pregnant**.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If **pregnant**, Due Date: \_\_\_\_\_ Name of OBGYN or Midwife \_\_\_\_\_

Where will you be birthing your baby?  Hospital  Home  Birthing Center  Other \_\_\_\_\_

# HEALTH, WELLNESS AND CHIROPRACTIC CARE

Please check off the following that apply to you:

## Digestive track

- Nausea & Vomiting
- Diarrhea
- Constipation
- Bloating feeling
- Stomach Pains or Cramps
- Heart Burn
- Blood and/or mucous in stools

## Ears

- Itchy ears
- Ear aches/infections
- Drainage from ear
- Ringing in ears
- Hearing loss
- Reddening of ears

## Emotions

- Mood swings
- Anxiety/fear/nervousness
- Anger/ aggressiveness
- Irritability
- Argumentative
- Frustrated/cries easily
- Depression

## Eyes

- Watery or itchy eyes
- Red/swollen/itchy eyelids
- Dark circles under eyes
- Blurred or tunnel vision

## Head

- Headaches
- Faintness
- Dizziness
- Insomnia/sleep disorder
- Facial flushing

## Heart

- Irregular/skipped beats
- Rapid/pounding beat
- Chest pain
- Congestive heart failure

## Joints & Muscles

- Pains/aches in joints
- Arthritis/osteoarthritis
- Stiffness/limited motion
- Pain/aches in muscles
- Feeling weak/tired
- Swollen/tender joints
- Psoriatic/gouty arthritis
- Rheumatoid arthritis

## Lungs

- Chest congestion
- Bronchitis
- Shortness of breath
- Difficulty breathing
- Persistent cough
- Wheezing
- Asthma

## Mind

- Poor memory
- Difficulty finishing projects
- Confusion
- Easily distracted
- Mild learning disabilities

## Mouth & Throat

- Chronic coughing
- Gagging/clear throat often
- Sore throat
- Hoarse voice/voice loss
- Swollen/discolored tongue
- Swollen/discolored lips
- Canker sores
- Itching on roof of mouth

## Nose

- Stuffy Nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucous

## Skin

- Acne
- Itching
- Hives/rash/dry skin
- Hair loss
- Flushing/hot flashes

## Weight

- Craving certain foods
- Excessive weight
- Water retention

## General

- Frequent illness
- Frequently take antibiotics
- Chronic Fatigue

## Genitourinary

- Frequent urination
- Urgent urination
- Kidney problems
- Urinary tract problems
- Bladder problems

## Other conditions

- Autism
- A.D.H.D.
- A.D.D
- Psoriasis
- Eczema
- Auto immune disorder
- Diabetes Type 1
- Diabetes Type 2
- OCD

## HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body which coordinates health is the CENTRAL NERVE SYSTEM. The vertebrae, (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the SPINE & NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to and **how they may relate to your present spinal, nerve and health status.**

### PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please indicate where and how you were birthed. (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

### PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had **ANY accidents or injuries in your life** related to any of the following? (Check all that apply.)

- Automobile       Motorcycle       Bicycle       Sports       Playground       Abuse

If yes, state **type of injury and date:**

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Have you ever **hurt/injured** your spine, head, neck, ribs, chest, upper or lower back, pelvis or hips?       Y       N

If yes, state **type of injury and date:**

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Have you ever **hurt, broken, fractured or sprained** any bones or joints?       Y       N

If yes, list **body parts injured and dates:**

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Have you ever been hospitalized?       Y       N

If yes, **state reason and dates:**

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### EMOTIONAL STRESS

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 below:

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

## CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you **vaccinated**?  Y  N If yes, did you have a **reaction**?  Y  N

Have you been **exposed to** any of the following on a regular basis, (past or present)?

- Toxic chemicals       Second hand smoke       Drug therapy  
 Radiation       Chemotherapy       Other

If yes, please list: \_\_\_\_\_

Do you have **allergies** to any foods?  Y  N **If yes, please list:** \_\_\_\_\_

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): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Note: It is imperative that you list all medications as they may have an influence on your care.**

## 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

Do you **exercise** regularly? If yes, how often? \_\_\_\_\_

Do you take **supplements**? If yes, please list: \_\_\_\_\_

Do you follow a **special dietary regime**? If yes, what? \_\_\_\_\_

\_\_\_\_\_

## EXPECTATIONS

I would like to have the following benefits from **Chiropractic Care**: (Check all that apply)

- Relief of a symptom or problem  
 Relief and prevention of a symptom or problem  
 Healthier spine and nerve system  
 Optimal health on all levels

## CHIROPRACTIC CLINICAL OBJECTIVE

Physical, Emotional and Chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic Exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

## FINANCIAL INFORMATION

Please indicate your method of payment.  Cash  Check  Credit Card  Insurance

## INSURANCE

Insurance coverage varies greatly. We cannot predict whether your policy will cover the services we provide **in our office**.

Please indicate below, the name of your insurance company.

**Health Insurance Co:** \_\_\_\_\_

**If you have Medicare, our staff will need a copy of your insurance card.**

**If this is an Auto Accident or a Work-Related injury, please provide us with the following information:**

Name of Auto Insurance Co: \_\_\_\_\_

Have you been treated elsewhere?  Emergency Room  Primary Care Doctor  Other

What services were provided?  MRI  X-Rays  Medication  Therapy  Other

## PLEASE READ AND SIGN BELOW

*The information I have provided on this case history form, is true and accurate to the best of my knowledge. I give the doctors at West Loop Chiropractic 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. I acknowledge that there are certain complications that can occur as a result of a spinal adjustment. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome, costovertebral strains and separation. Rare complications include stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of the adjustment. I am aware of these complications, and in order to minimize them the doctor will take a detailed clinical history of you as well as an examination for any defect which would cause a complication. This examination may include x-rays which may pose a risk if you are pregnant. Let the doctor know if you are pregnant.*

**Signature** \_\_\_\_\_ Today's Date \_\_\_\_\_

Signature of Parent (for minor): \_\_\_\_\_ Today's Date \_\_\_\_\_

***Thank you for choosing West Loop Chiropractic.  
We look forward to helping you.***

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date