

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

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:**

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:**

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

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

Have you ever been hospitalized? Y N

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

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 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.

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