

HEALTH, WELLNESS AND CHIROPRACTIC CARE

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

Today's Date _____

PERSONAL DATA

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 _____

Business Address _____ City _____ State _____ Zip _____

SS# (opt'l) _____ Emergency contact _____

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 concerns do you feel Denette Family Chiropractic can address for you?

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

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

On a scale of 1-10, how is this affecting your life?

Little affect Great affect
1 2 3 4 5 6 7 8 9 10

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

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? _____

FOR WOMEN

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 _____

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 **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 **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 occurs 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? _____

- Aspects of wellness you want for yourself:
- | | | |
|---|--|--|
| <input type="checkbox"/> More Energy | <input type="checkbox"/> Better Sleep | <input type="checkbox"/> Freedom from pain |
| <input type="checkbox"/> Better Concentration | <input type="checkbox"/> Enhanced emotional well-being | <input type="checkbox"/> Reduce/eliminate medication use |
| <input type="checkbox"/> Improved digestion | <input type="checkbox"/> Improved strength and endurance | <input type="checkbox"/> Greater Resistance to disease |
| <input type="checkbox"/> Easier breathing | <input type="checkbox"/> Better sports performance, reaction time/reflexes | <input type="checkbox"/> Overall health improvement |
| <input type="checkbox"/> Deeper relaxation | <input type="checkbox"/> More balanced posture | |

Additional goals for yourself: _____

Additional goals you want for you family: _____

The information I have provided, on this case history form, is true and accurate, to the best of my knowledge. I give Daniel Denette, D.C and Kristen Denette, D.C. 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 Denette Family Chiropractic.
We look forward to helping you.*