



Chiropractic First

Personal Health History Form

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Work: _____

Would you like to be added to our mailing list to receive our monthly newsletter? Yes No

E-mail: _____

Which is your preferred contact? Please indicate which phone number or email: _____

Date of Birth: _____ Age: _____ Female Male

Marital/Partnership status: _____ # of Children: _____

Insurance Provider: _____

How did you hear about Dr. Meggie Smith or Chiropractic First? _____

Have you had chiropractic care in the past? Yes No Did you find it helpful? Yes No

Are you taking any medications? Yes No If yes, please list and include any over the counter medication. If more than three please use extra space on page 3.

Medication Name	Dosage & Frequency (i.e. 5mg 1 x day /Capsule or Tablet)

Primary Concern(s)

What brings you into the office today: _____

-Continue on reverse -

Name: _____

Have you done anything or sought treatment for this situation or condition? If so, what were you told? _____

What was *done*: _____

Did it seem to work? Yes No

Why do you think this has happened (or continues) to happen to you? _____

Do any of your family members have similar concerns? Yes No If so, who: _____

- What is your desired outcome for this concern?: Patch up the immediate problem/decrease the symptoms
 Address the deeper problems & build a solid foundation
 Experience new degree of health & healing

Please check any of the following additional concerns:

- | | | |
|---|---|---|
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Muscle Tension / Tightness | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Decreased Motion | <input type="checkbox"/> Sweats |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Loss of Taste or Smell | <input type="checkbox"/> Cold Hands / Feet |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Trouble Sleeping |
| <input type="checkbox"/> Weight Changes | <input type="checkbox"/> Numbness / Loss of Sensation | <input type="checkbox"/> Other: _____ |

Which of the following would you like to experience more of in your life?

- | | | |
|---|---|--|
| <input type="checkbox"/> Mental Clarity / Focus | <input type="checkbox"/> Breathing with Ease | <input type="checkbox"/> Awareness of Life Purpose |
| <input type="checkbox"/> Emotional Awareness | <input type="checkbox"/> Comfort Sitting / Standing | <input type="checkbox"/> Ease in Relationships |
| <input type="checkbox"/> Ease in Digestion | <input type="checkbox"/> Centered in Body | <input type="checkbox"/> Musculoskeletal Flexibility |
| <input type="checkbox"/> Interest in Life | <input type="checkbox"/> Energy / Vitality | <input type="checkbox"/> Adaptability to Change |
| <input type="checkbox"/> Positive Feelings About Self | <input type="checkbox"/> Enjoyment of Life | <input type="checkbox"/> Motivation / Productivity |

Name: _____

Please check all that apply either currently or in the past:

- | | | |
|--|--|---|
| <input type="checkbox"/> Regular Exercise | <input type="checkbox"/> Extensive Computer Work | <input type="checkbox"/> Repetitive Lifting / Bending |
| <input type="checkbox"/> Past Serious Illness | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Chronic Childhood Illness |
| <input type="checkbox"/> Financial Stress | <input type="checkbox"/> High Stress Work | <input type="checkbox"/> High Stress at Home |
| <input type="checkbox"/> Artificial Sweeteners | <input type="checkbox"/> Alcohol Consumption | <input type="checkbox"/> Extensive Travel Abroad |
| <input type="checkbox"/> Tobacco Use | <input type="checkbox"/> "Low Fat" Processed Foods | <input type="checkbox"/> Regular Spiritual Practice |
| <input type="checkbox"/> Tendency to withhold emotions | <input type="checkbox"/> Drug Use | <input type="checkbox"/> Vegetarian Diet |
| <input type="checkbox"/> Traumatic Birth | <input type="checkbox"/> Present Serious Illness | <input type="checkbox"/> Psychotherapy |
| <input type="checkbox"/> Car Accident(s) | <input type="checkbox"/> Extensive Family / Social Support | <input type="checkbox"/> Sickness / Loss of Loved One |

Please list all current vitamins and/or supplements you are taking: _____

Please list all surgeries, accidents, or hospitalizations since childhood: _____

Do you relate any of the above to your current state of health? Yes No

If so, which ones: _____

Continued from page 1

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