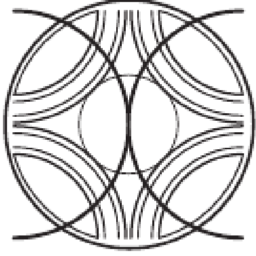

Chiropractic First

Personal Health History Form

Name: ______________________________ Date:____________________

Address: ____

City: ______________________ State: ________ Zip: ____________________

Phone:____________________ Cell: ____________________ Work:________________

E-mail: ____

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

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

Date of Birth: ______/_____/______ Age: ______________ ☐ Female ☐ Male

Marital/Partnership status: ______________________ # of Children: __________________

Insurance Provider: ____________________Insured's DOB:_____/_____/______

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:

☐ Muscle Pain	☐ Heartburn	☐ Anxiety
☐ Muscle Tension / Tightness	☐ Muscle Weakness	☐ Headaches
☐ Joint Pain	☐ Allergies	☐ Depression
☐ Fatigue	☐ Decreased Motion	☐ Sweats
☐ Ringing in Ears	☐ Dizziness	☐ Digestive Problems
☐ Shortness of Breath	☐ Loss of Taste or Smell	☐ Cold Hands / Feet
☐ High Blood Pressure	☐ Mood Swings	☐ Trouble Sleeping
☐ Weight Changes	☐ Numbness / Loss of Sensation	☐ Other: ______________________

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

☐ Mental Clarity / Focus	☐ Breathing with Ease	☐ Awareness of Life Purpose
☐ Emotional Awareness	☐ Comfort Sitting / Standing	☐ Ease in Relationships
☐ Ease in Digestion	☐ Centered in Body	☐ Musculoskeletal Flexibility
☐ Interest in Life	☐ Energy / Vitality	☐ Adaptability to Change
☐ Positive Feelings About Self	☐ Enjoyment of Life	☐ Motivation / Productivity

Name: ____

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

□ Regular Exercise	□ Extensive Computer Work	□ Repetitive Lifting / Bending
□ Past Serious Illness	□ Physical Abuse	□ Chronic Childhood Illness
□ Financial Stress	□ High Stress Work	□ High Stress at Home
□ Artificial Sweeteners	□ Alcohol Consumption	□ Extensive Travel Abroad
□ Tobacco Use	□ "Low Fat" Processed Foods	□ Regular Spiritual Practice
□ Tendency to withhold emotions	□ Drug Use	□ Vegetarian Diet
□ Traumatic Birth	□ Present Serious Illness	□ Psychotherapy
□ Car Accident(s)	□ Extensive Family / Social Support	□ 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

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