Cloud 9 Chiropractic Wellness Center Health History Form

PERSONAL DATA

Today's Date _____

Name _____ Age _____ Date of Birth _____

Parent's Names (if you are under 18) _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Business Phone (_____) _____

Cell Phone (_____) _____ E-Mail Address _____

Occupation _____ Employer _____

Business Address _____ City _____ State _____ Zip _____

SSN (opt'l) _____ Weight _____ Height _____

Emergency Contact (Name and Phone) _____

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 Cloud 9 Chiropractic can address for you? _____

_____

Please mark what best describes your pain: ❑ Sharp ❑ Dull ❑ Burning

Mark an X to show how intense your pain is today: (0 no pain) 0 1 2 3 4 5 6 7 8 9 10 (10 extreme pain)

Is it: ❑ Getting Better ❑ Worse ❑ About the Same When did it start? _____

What is it keeping your from? (Please mark 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 _____

FOR WOMEN

Are you pregnant? ❑Y ❑N Date of Last Mentrual 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 OB/GYN or Midwife _____

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

The primary system in the body which coordinates health is THE CENTRAL NERVOUS 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 & INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine and nerve system. Please indicate where and how you were birthed. (If you do not know, please skip so the 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 and 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, nect, ribs, chest, upper or lower back, pelvis or hips? ❑Y ❑N

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

_____

_____

_____

_____

Have you every been hospitalized? ❑Y ❑N

If yes, state ***resason 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	Parent's Divorce	❑Y	❑N	Illness	❑Y	❑N

Please explain any "yes" answers _____

_____

_____

_____

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? (Check all that apply)

❑ Toxic Chemicals ❑ Second Hand Smoke ❑ Drug Therapy

❑ Radiation ❑ Chemotherapy ❑ Other

If yes, please list: _____

Do you have **allergies** to any food? ❑Y ❑N **If yes, please list**:_____

_____

Do you **consume** any of the following presently? (Check all that apply)

❑ Diet Foods ❑ Soda ❑ Dairy ❑ Processed Foods

❑ Coffee/Caffeine ❑ Alcohol ❑ Tobacco ❑ Prescribed Drugs

❑ Refined Sugar ❑ Fried Foods

Please list all medications and why you are taking them (prescribed and over the counter): _____

_____

_____

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

Past Health History

Please mark the following conditions you may have had or have now (**- have had, + have now**):

❑ Alcoholism	❑ Allergy	❑ Anemia	❑ Arteriosclerosis	❑ Arthritis	❑ Asthma
❑ Back Pain	❑ Cancer	❑ Cold Sores	❑ Constipation	❑ Convulsions	❑ Depression
❑ Diabetes	❑ Diarrhea	❑ Eczema	❑ Emphysema	❑ Epilepsy	❑ Gall Bladder Problems
❑ Gout	❑ Headaches	❑ Heart Attack	❑ Heart Disease	❑ High Blood Pressure	❑ HIV (Aids)
❑ Irregular Periods	❑ Low Blood Sugar	❑ Malaria	❑ Measles	❑ Menstrual Cramps	❑ Migraines
❑ Miscarriage	❑ Multiple Sclerosis	❑ Mumps	❑ Neck Pain	❑ Nervousness	❑ Neuritis
❑ Pleurisy	❑ Pneumonia	❑ Polio	❑ Rheumatic Fever	❑ Ringing in Ears	❑ Sinus Problems
❑ Stroke	❑ Thyroid Problems	❑ Tuberculosis	❑ Ulcers	❑ Venereal Disease	❑ Whooping Cough

Other (please explain):

_____

_____

_____

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? _____

_____

What lesson(s) have you taken home from your healing process to date? _____

_____

_____

_____

YOUR GOALS & 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

❑ Optimal health on all levels

Please mark below and "X" where you believe your health is and an "O" where you would like to be.

NeuroSpinal Function Index (NSF)