THERIOT FAMILY CHIROPRACTIC CENTER

Personal and Family Health History

Name_______________________________________ Referred By ______________________________________

Date_________________ Social Security # ________________________________

Address_____________________________________ Occupation_______________________________________

City_________________State______ Zip_________ Employer____

Phone(H)________________(W)______________ Marital Status S M D W

E-mail ______________________________________ Spouse's Name _________________________________

Date of Birth__________________(Age________) Spouse's Occupation ______________________________

Number of Children and Ages

Name_________________________ Age______

Name_________________________ Age______

Name_________________________ Age______

Name_________________________ Age______

Previous Chiropractic Care?

Yes___ No___ Reason ___________________________

Yes___ No___ Reason ___________________________

Yes___ No___ Reason ___________________________

Yes___ No___ Reason ___________________________

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blueprints, intelligence, tools, and systems to live an active, healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Circle all that Apply	**Patient**	**Spouse**	**Child #1**	**Child #2**	**Child #3**	**Chiropractor's Comments**
1. Was your Birth Traumatic?	Y	Y	Y	Y	Y	____________________
Long delivery?	Y	Y	Y	Y	Y	____________________
Difficult delivery?	Y	Y	Y	Y	Y	____________________
Forcepts?	Y	Y	Y	Y	Y	____________________
Caesarian?	Y	Y	Y	Y	Y	____________________
Breach/Cephalic?	Y	Y	Y	Y	Y	____________________
Home birth?	Y	Y	Y	Y	Y	____________________
Mother given drugs during delivery?	Y	Y	Y	Y	Y	____________________
Induced labor?	Y	Y	Y	Y	Y	____________________
2. Growth and Development						
Did you ever once…						
Learn to care for your spine?	Y	Y	Y	Y	Y	____________________
Fall out of bed?	Y	Y	Y	Y	Y	____________________
Bang your head?	Y	Y	Y	Y	Y	____________________
Breastfeed?	Y	Y	Y	Y	Y	____________________
Childhood sickness?	Y	Y	Y	Y	Y	____________________
Have any accidents?	Y	Y	Y	Y	Y	____________________
Have surgery?	Y	Y	Y	Y	Y	____________________
Take drugs?	Y	Y	Y	Y	Y	____________________
Fall while learning to walk?	Y	Y	Y	Y	Y	____________________
Bullied by your siblings?	Y	Y	Y	Y	Y	____________________
Child abuse?	Y	Y	Y	Y	Y	____________________
Spanking?	Y	Y	Y	Y	Y	____________________
Pulled ear/chin?	Y	Y	Y	Y	Y	____________________
Other?	Y	Y	Y	Y	Y	____________________
Chair pulled out when sitting?	Y	Y	Y	Y	Y	____________________
Fall down the stairs?	Y	Y	Y	Y	Y	____________________
Pulled by your arm?	Y	Y	Y	Y	Y	____________________
Experience other traumas?	Y	Y	Y	Y	Y	____________________
3.Current Health Habits						
Did/do you…						
Smoke?	Y	y	y	Y	Y	____________________
Drink alcohol?	Y	Y	Y	Y	Y	____________________

Diet (do you eat healthy foods?)	Y	Y	Y	Y	Y	____________________
Have you been in accidents?	Y	Y	Y	Y	Y	____________________
Have you had surgery?	Y	Y	Y	Y	Y	____________________
Have any organs replaced/removed?	Y	Y	Y	Y	Y	____________________
Drugs?(prescriptive or Non-Prescriptive)	Y	Y	Y	Y	Y	____________________
Have teeth problems?	Y	Y	Y	Y	Y	____________________
Have eye problems?	Y	Y	Y	Y	Y	____________________
Have hearing problems?	Y	Y	Y	Y	Y	____________________
Exercise regularly?	Y	Y	Y	Y	Y	____________________
Have sleeping problems?	Y	Y	Y	Y	Y	____________________
Have occupational stress?	Y	Y	Y	Y	Y	____________________
Have mental stress?	Y	Y	Y	Y	Y	____________________
Have hobbies/sports injuries?	Y	Y	Y	Y	Y	____________________
What is your sleeping posture?	Side	Stomach	Back			____________________

Current Health Condition

Present complaint (be brief) reason for your visit today____________________

Pain or problem started when____________________

Pains are: Sharp Dull Constant Intermittent (comes and goes)

On a 0-10 scale (0= no pain 10= the most pain imaginable) How severe is it?____________________

What activities aggravate your condition/pain? ____________________

What activities lessen your condition/pain? ____________________

Is condition worse during certain time of the day? ____________________when?____________________

Is this condition interfering with work? ________ Sleep? ________ Routine? ________ Other?____________________

Is this condition getting progressively worse? ____________________

Other Doctors seen for this condition____________________

Any home remedies? ____________________

Other symptoms:

Headaches	Face flushed	Light bothers eyes	Feet cold
Neck pain	Neck stiff	Loss of memory	Hands cold
Sleeping problems	Pins & needles in legs	Ears ring	Stomach upset
Back pain	Pins & needles in arms	Fever	Constipation
Nervousness	Numbness in fingers	Fainting	Tension
Numbness in toes	Cold sweats	Buzzing in ear	Irritability
Shortness of breath	Loss of smell	Chest pains	Fatigue
Loss of taste	Dizziness	Depression	Diarrhea

Have you been under drug and/or medical care? ____________________

What medications are you taking? ____________________

How long? ______________ Have you had surgery? ____________ What? ______________ When?______________

What side effects have you experienced from the drugs and surgery? ____________________

Is there a family history of: Heart Disease? Arthritis Cancer Diabetes Other______________

Father's side

Mother's side

Are your parents still alive? ____________ How did they die? ______________ At what age? ______________

Upon the completion of your first visit, you will receive a Chiropractic Report to discuss the different types of Active Life Plans that are available to you. Chiropractic Active Life Plans are designed to help get you feeling better quickly, and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Active Life Plans prior to your Chiropractic Report appointment so you can choose the level of participation that supports you in reaching all of your health goals.

As a result of my chiropractic care, I would like to:
(please check all that apply)

feel better quickly.

have a healthier spine.

have a healthier body by keeping my nerve system healthy.

live a healthier lifestyle.

______________________________ ______________________

signature date