PERSONAL & FAMILY HEALTH HISTORY - ADULT

1. Personal Information

Date: ______/______/__________

Name: ___________________________________

Home Address:

____

____

____

City: ______________________ State: ________

Zip Code: ________________

Phone Numbers:

Home: (_____) ______________________

Mobile: (_____) _____________________

**Please notify us if you do not want to receive text message appointment reminders.*

E-mail: __________________________________

** We will **NOT** share your email with any third parties. We will only use your email to contact you in relation to your care with our practice.*

Date of Birth: ______/______/__________

Age: _________

Occupation: __________________________________

Employer: ____________________________________

Marital Status:

❒ Single ❒ Married ❒ Divorced ❒ Widowed

Spouse/Partner Name: ________________________

Number of Children: ________

Emergency Contact: ____________________________

Emergency Phone: (_____) ____________________

How Did You Find Out About Us?

Referred By: __________________________________

____

____

PERSONAL & FAMILY HEALTH HISTORY

Our Pledge to Protect Your Privacy

Eclipse Chiropractic knows that medical information about you is personal and is committed to protecting the privacy of your information. As a patient of this office, the care and treatment you receive is recorded in an electronic medical record. Upon electronic entry, all paper documents are destroyed. We share your information only to the extent necessary to conduct our business operations, to collect payment for the services we provide you and to comply with the state and federal laws that govern health care. We will not use or disclose your personal health information for any other purpose without your written permission.

2. Current Health Condition

If You Are Only Here for Chiropractic Wellness Services, You Can Skip this Section

Present Complaint(s): ____

____

Please Describe Your Current Pain or Discomfort: ____

____

When Did This Pain or Problem Start: ______/______/__________

Currently, My Pain is…………………… ❒ Sharp ❒ Dull ❒ Constant ❒ Intermittent ❒ Debilitating

Select Frequency You Experience Pain from This Condition:

❒ Always ❒ Hourly ❒ Daily ❒ Occasionally ❒ Other ___________________________

What Activities Aggravate Your Condition/Pain? ____

____

Where Did the Injury Occur?

❒ Automobile Accident ❒ Work ❒ 3rd Party Premises ❒ Other ___________________________

Date of Injury: ______/______/___________

What Activities Lessen Your Condition/Pain? ____

Is Condition Worse During Certain Times of the Day? ____

Is This Condition Interfering with Any of the Follow? ❒ Work? ❒ Sleep? ❒ Routine?

❒ Other? ____

Is This Condition Getting Progressively Worse? ❒ No ❒ Yes

Other Doctors Seen for This Condition: ____

3. Personal Health History

Please List Any Health Conditions That You Have Been Treated for in The Last Year:

____

____

____

____

Have You had Previous Chiropractic Care? ❒ Yes ❒ No

Condition Treated: ____

____

____

Date of Last Visit: ______/______/__________

Are You Pregnant, or Have Any Signs of Pregnancy? (***Female Only***) ❒ Yes ❒ No

Are You Planning to Get Pregnant in the Next 12 Months? (***Female Only***) ❒ Yes ❒ No

List Current Medications: ____

____

List Current Vitamins, Minerals, Supplements, or Herbs: ____________________________________

____

PERSONAL & FAMILY HEALTH HISTORY

4. Personal Incident History

Broken Bones? ❒ Yes ❒ No

If Yes: Did You Get Professional Care?

❒ Yes ❒ No

Briefly Explain: ____________________________

____

Been Hospitalized? ❒ Yes ❒ No

If Yes: Briefly Explain: ____________________

____

____

Been Struck Unconscious? ❒ Yes ❒ No

If Yes: Briefly Explain: ____________________

____

____

Had Major Sprain/Strain? ❒ Yes ❒ No

If Yes: Briefly Explain: ____________________

____

Had Surgery? ❒ Yes ❒ No

If Yes: Briefly Explain: ____________________

____

Been in an Auto Accident? ❒ Yes ❒ No

If Yes: Briefly Explain: ____________________

____

____

Did You Get Professional Care? ❒ Yes ❒ No

If Yes: Briefly Explain: ____________________

____

5. Current Health Habits

Did or Do You Currently...

Smoke Cigarettes or Cigars	Y	N	Have Hearing Problems	Y	N
Drink Alcohol Regularly	Y	N	Exercise Regularly	Y	N
Diet (Eat Healthy Foods)	Y	N	Have Occupational Stress	Y	N
Take Drugs (Illegal)	Y	N	Have Physical Stress	Y	N
Have Teeth Problems	Y	N	Have Mental Stress	Y	N

PERSONAL & FAMILY HEALTH HISTORY

6. Other Symptoms

I am Currently Experiencing… (Please Check All That Apply)

- ❐ Headaches
- ❐ Neck Pain
- ❐ Sleeping Problems
- ❐ Back Pain
- ❐ Nervousness
- ❐ Tension
- ❐ Irritability
- ❐ Chest Pains
- ❐ Dizziness
- ❐ Face Flushed
- ❐ Neck Stiffness
- ❐ Pins & Needles in Legs
- ❐ Pins & Needles in Arms
- ❐ Numbness in Fingers
- ❐ Numbness in Toes
- ❐ Shortness of Breath
- ❐ Fatigue
- ❐ Depression
- ❐ Light Bothers Eyes
- ❐ Loss of Memory
- ❐ Ear(s) Ring
- ❐ Fever
- ❐ Fainting
- ❐ Cold Sweats
- ❐ Loss of Smell
- ❐ Loss of Taste
- ❐ Excess Stress
- ❐ Diarrhea
- ❐ Feet Cold
- ❐ Cold Hands
- ❐ Upset Stomach
- ❐ Constipation
- ❐ Loss of Balance
- ❐ Buzzing in Ears

7. Family History

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side:	❐	❐	❐	❐	❐
Mother's Side:	❐	❐	❐	❐	❐

Please Explain (Other): ____

____

____

____

____

____

PERSONAL & FAMILY HEALTH HISTORY

As a Result of My Care at Eclipse Chiropractic, I Would Like to…

(Please Check All That Apply)

❒ Feel Better Quickly

❒ Have a Healthier Spine and Nervous System

❒ Live a Healthier Lifestyle

❒ Other: ____________________________________

____

Were You Aware That…

Doctors of Chiropractic Work with the Nervous System? ❒ Yes ❒ No

The Nervous System Controls all Bodily Function and Systems? ❒ Yes ❒ No

Chiropractic is the Largest Natural Healing Profession in the World? ❒ Yes ❒ No

____
(Date)

____
(Signature)

____
(Print Name)

____ ___________________
(City) (State)

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